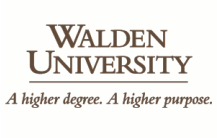

2017

Influence of Leadership Styles on Expatriate Nurses' Professional Integration in the UAE

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Walden University
2017

Abstract

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Honors BA (Health Studies), University of South Africa, 2012

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

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Abstract

Transnational nurse migration has evoked a growing interest in the phenomenon of professional integration of expatriate nurses into their host societies. Despite research connecting employee and organizational outcomes such as job satisfaction and organizational citizenship behavior to the quality of leadership styles, there remains a lack of research linking professional integration of expatriate nurses to nurse leadership styles in the UAE. The purpose of this grounded theory study was to develop a theory that would explain how nurse leadership styles and behaviors impacted the professional integration of expatriate nurses into the multicultural work environment of the UAE. The research questions addressed the perceptions of the expatriate nurses on effective leadership styles and behaviors of nurse leaders in a culturally diverse work environment, the lived experiences of the expatriate nurses, and the impact of the organizational culture on the process of integration. Data were collected through in-depth semistructured interviews with 10 expatriate nurses, demographic surveys, documents review, and researcher memos. Data were analyzed using the constant comparative method and initial, focused, axial, and theoretical coding. Results indicated that nurse leadership styles and the conditions surrounding the integration process influenced the success of the expatriate nurses' adaptation, integration, and assimilation into the host society. Implications for social change include the preparation of nurses while in their home country on what to expect in the host country, and development of leadership training programs to prepare nurse leaders for leading in a culturally diverse work environment.

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Dedication

This dissertation is dedicated first of all to God, who sustained me and gave me the enabling grace and ability to fulfill my dream of attaining a doctorate. I also dedicate it to my brothers, sisters, nephews, nieces, and the rest of my extended family who stood by me, supported me, encouraged me, and understood when I had to suspend communication to focus on my studies. This dissertation is also dedicated to my late father, Anderson Martin Ncube, who believed in me and encouraged me to be the best I could ever be in life. My father may not be here now to witness my attaining the PhD, but I know he is looking down on me with pride.

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I am grateful to everybody who helped me throughout my PhD program, including my family who prayed for me and supported me and my friends and colleagues who listened to me whenever I needed to talk. I would also like to thank the faculty at Walden University who guided me through my goal of becoming a scholar-practitioner, especially my dissertation committee chair and content expert, Dr. Leslie Hussey; my committee member and methodology expert, Dr. Corinne Wheeler; and the university research reviewer, Dr. David Sharp. I would never have managed to complete the dissertation without their guidance, direction, and support.

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Chapter 1: Introduction to the Study

Transnational nurse migration has evoked a growing interest in the phenomenon of professional integration of expatriate nurses into their host societies (Ho & Chiang, 2015; Primeau, Champagne, & Lavoie-Tremblay, 2014; Zhou, 2014). Nurse migration in turn has been triggered by push factors such as low salaries, lack of resources, political factors, poor working conditions, and limited educational opportunities in the source countries. Pull factors include a shortage of nurses in developed countries such as the United States of America, Canada, Australia, and the United Kingdom; improved quality of life; and opportunities for career progression (Li, Nie, & Li, 2014). Countries with high national per capita incomes such as the United Arab Emirates (UAE) are recruiting internationally educated nurses (El Amouri & O'Neill, 2014). Professional integration is a process of professional resocialization into a new organizational culture among professionals such as nurses, where the nurses modify both their professional practices and professional identity as they transition and integrate into the new work environment (Neiterman & Bourgeault, 2015b).

The process of professional integration of expatriate nurses does not take place in a vacuum, but occurs in and is influenced by an organization's sociocultural system and the organizational structure (Ho & Chiang, 2015). The organizational structure includes the nurse leaders who have oversight of the environments in which the expatriate nurses work, and in a sense possess a professional vote in the expatriate nurses' integration process (Likupe, 2015). Nurse leaders influence the work environment through the leadership styles and behaviors they exhibit, where poor leadership can lead to negative

effects such as psychological and physical stress among employees. Conversely, effective leadership promotes a positive work environment with motivated and engaged staff (Kallas, 2014). In addition, the quality of the leadership styles and behaviors has attracted attention in determining the effect of the leader-member exchange relationship in relation to international staff shortages and, by the same token, job satisfaction (Lornudd, Tafvelin, von Thiele Schwarz, & Bergman, 2015). Apart from psychological stress, other documented detrimental effects of poor nurse leadership include somatic conditions such as ischemic heart disease, obesity, and the related type 2 diabetes (Lornudd et al., 2015).

Qualitative, quantitative, and mixed-methods researchers have addressed the experiences of expatriate nurses as they strive toward professional integration and acculturation into the host countries (Ho & Chiang, 2014; Goh & Lopez, 2016; Primeau et al., 2014; Zhou, 2014), while little research has addressed the process of integration (Neiterman & Bourgeault, 2015b). Additionally, even fewer researchers have investigated how leadership styles and behaviors influence the process of professional integration among expatriate nurses (Likupe, 2015; Xiao, Willis, & Jeffers, 2014). Nurse migration is forecasted to increase as the nursing shortage in developed countries is set to increase with the aging current workforce and an aging population due to longevity, and about 274,000 registered nurses will be needed within the next 10 years in the United States alone (Li et al., 2014).

The phenomenon of transnational nurse migration is forecasted to prevail due to factors such as changing demographics, longevity, emergence of new diseases, prevalence of chronic conditions, and an aging workforce (Xiao et al., 2014; Walani,

2015). Understanding the interface between nurse leaders' behaviors and the professional integration process of expatriate nurses could help to put in place systems that could ease professional integration. The process of integration, adaptation, and assimilation of expatriate nurses into the host countries and work environments has been cited as being fraught with difficulties such as racism, culture shock, discrimination, isolation, and exclusion (Ho & Chiang, 2014; Moyce, Lash, & de Leon Siantz, 2015). Nurse leaders can also play a part by ensuring that their leadership styles and behaviors facilitate rather than impede the smooth transitioning and integration of expatriate nurses into the new work environment.

The constructivist grounded theory approach described by Charmaz (2014) was used to explore the influence of nurse leaders' styles and behaviors on the professional integration of expatriate nurses; this approach led to the development of a theory that would help to understand or explain this phenomenon. This understanding has the potential to help stakeholders improve or develop structures that could make the transition process of expatriate nurses easier, to prevent potential detrimental effects of nurse migration, and to promote favorable patient outcomes.

In this chapter I provide an introduction to the study, the background of the study, and a description of the problem and the purpose of the study. I also present the research questions, guiding conceptual framework, nature of the study, assumptions, and limitations and delimitations. Lastly, I discuss the significance of the study and the implications for practice and social change, and conclude with a summary of the chapter.

Background

Transnational nurse migration has attracted the attention of social science researchers, nursing scholar-practitioners, and health planners over the last 10 years (Neiterman & Bourgeault, 2015b; Prescott & Nichter, 2014). Nurses migrate in response to pull factors, which are the factors in the destination countries that attract the nurses, and push factors, which are the factors in the home country that force nurses to migrate (Prescott & Nichter, 2014). Pull factors such as the prospect of better quality of life, safe working conditions, the ability to transfer nursing skills globally, the global nursing shortage, opportunities for professional advancement, and attractive remuneration packages have influenced the migration of nurses (Li et al., 2014). Push factors such as poor working conditions, unstable economic and political systems, and lack of career prospects have encouraged nurses to leave their countries (Santy-Tomlinson, 2015). The global nursing shortage is as high as 4.3 million, resulting from changing population demographics, increasing prevalence of diseases such as type 2 diabetes and end-stage renal disease, longevity, an aging nursing workforce, and shortage of nurse educators (Walani, 2015). Nurse migration generally flows from developing countries to countries with a high per capita such as the United States, United Kingdom, Canada, Australia, and New Zealand, and also from the global south to the west (Neiterman & Bourgeault, 2015b). Expatriate nurses not only fill the nursing shortages in the developed countries, but they also reduce the turnover rates in the host countries and have been found to be flexible and willing to work in different clinical areas (Mazurenko, Gupte, & Shan, 2014).

The UAE is located in the Arabian Gulf Cooperation Council region (GCC), with countries such as Saudi Arabia, Qatar, Oman, Bahrain, and Kuwait. These countries share similar cultural, ethnic, and religious backgrounds, and have developed rapidly over the past 50 years from being nomadic societies to strong economies with metropolitan cities (Al Yateem, Al Yateem, & Rossiter, 2015; El Amouri & O'Neill, 2011). The discovery of oil led to the economic and population growth in countries such as the UAE (El Amouri & O'Neill, 2011, 2014). The developments occurred rapidly and on a wide scale, and included the building of several hospitals and clinics built along international standards (Al Yateem et al., 2015). Unfortunately, this growth has not been on par with the local human resources, and has pushed the governments in the GCC region to meet the quality patient care requirements such as adequate staffing by resorting to overseas recruitment of nurses (Al Yateem et al., 2015).

Due to its strong economic growth and concomitant population growth, political stability, and respect for human rights, the UAE has attracted foreign workers who include expatriate nurses (Bealer & Bhanugopan, 2014). El Amouri and O'Neill (2014) added that 80% of the UAE population consists of foreigners, and the same demographic picture extends to the health care settings. Most of these expatriate employees come from non-Muslim countries and have little knowledge and understanding of Muslim cultures, values, and beliefs (Almutairi, Gardner, & McCarthy, 2013; Al Yateem et al, 2015). According to Yateem et al. (2015), this leads to perceptions of cultural incompetency of nurses by the local people, as well as feelings of inadequacy and culture shock by the expatriate nurses. Almutairi et al. (2013) added that health care providers who are not

aware of the vital role played by culture and religion could inadvertently cause cultural injury and dissatisfaction among health care consumers. Unfamiliar health care practices in the GCC region such as changing medication times and regimens to suit prayer times, food prohibitions, fasting periods, and male-female segregation could prove problematic for expatriate nurses newly arrived to the UAE and other countries in the GCC region (Almutairi et al., 2013; Al Yateem et al., 2015). These stressors have been cited as leading to turnover of expatriate nurses, even though no specific figures have been recorded centrally in the UAE. However, at one acute care hospital, at least 10 nurses out of about 40 absconded or resigned within their 3-months probation period (Human resources manager, personal communication, December 9, 2016). This study may help to elucidate the effects of acculturation on expatriate nurses, and may also help to identify ways through which the nurse leadership could alleviate the problems.

Neiterman and Bourgeault (2015b) argued that when professional nurses migrate to other countries, they undergo a process of professional resocialization to be able to integrate into the host country's health care system and structure. As mentioned earlier, the phenomenon of transnational migration of nurses has been around for over three decades, and nurses have been migrating in keeping with skilled workers' global migration trends (Delucas, 2014; Rumsey, Thiessen, Buchan, & Daly, 2016). The expatriate nurses reported increased interest in nurse migration as they transitioned into the new work environment (Walani, 2015). Nurse researchers also were interested in the effects of the movement of nurses on the donor countries (Marcus, Quimson, & Short, 2014). Therefore, nurse scholars, social scientists, national health care regulators, the

World Health Organization, and the International Council of Nurses have increasingly sought to gain a better understanding of the perceptions of expatriate nurses' experiences during the transition periods, and also to monitor and control any irregularities and unethical international nurse recruitment (Delucas, 2014).

Problem Statement

Migration of skilled workers is an inevitable but economically beneficial part of the 21st century, with about 214 million migrants internationally (Ohr, Jeong, Parker, & McMillan, 2014; Sherwood & Shafer, 2014). Labor migration has resulted in workforce diversity in terms of culture, nationality, and demographics (Benton, González-Jurado, & Beneit-Montesinos, 2014; Girdauskiene & Eyvazzade, 2015). Health care professionals who migrate transnationally have to undergo professional, cultural, and educational adjustments to assimilate into the new work environment (Prescott & Nichter, 2014). The process of professional integration has been explored in relation to nurse migration issues such as immigration, language, professional registration, cultural competence, and perceived institutional discrimination (Moyce et al., 2015; Xiao et al., 2014). Some researchers found that expatriate nurses experienced considerable challenges during their integration into the host societies, which included discrimination, deskilling, language barriers, social isolation, stress, and acculturation issues (Walani, 2015).

The quality of leadership vis-à-vis the organizational goals and outcomes and the effective management of human resources has been the center of focus for many decades, and this has led to the development of different leadership theories (Kallas, 2014; McCabe & Sambrook, 2013; Saleem, 2015). The changing demographics in the

workplace, global business competitiveness, and migration of workers are adding to the demands placed on leaders (Washington, 2015). The nurse leader's actions impact the way new nurses integrate into the unit or health care organization. Nurses can either perceive that they have been supported and helped to integrate successfully, or they can feel they have been left to fumble alone through the unfamiliar nursing territory. Researchers in the field of leadership have examined leadership styles and behaviors in relation to positive and negative work environments, burnout, turnover, and organizational citizenship behaviors (Arnold, Connelly, Walsh, & Ginis, 2015; Baysak & Yener, 2015). Favorable leadership styles such as empowering leadership encourage autonomy among new employees such as expatriate nurses, and promote the transferability of professionalism (Amundsen & Martinsen, 2014a; Moyce et al., 2015). Neiterman and Bourgeault (2015b) found that expatriate nurses encountered challenges with transferring their professional status from their home countries, and had to accept nursing posts that were otherwise inferior.

Leading a multicultural and diverse workforce requires considerable adaptation by the leaders (Washington, 2015). As more health care workers migrate to other countries and the health care organization landscape continues to change, nurse leaders may need to develop and adopt novel leadership styles to positively influence their work environments. Leadership styles have been examined in relation to leader-member exchange relationships in general, the effectiveness of specific leadership styles, and effects on the organizational outcomes (Arnold et al., 2015). Although many studies addressed leadership styles, there was a paucity of studies focusing on how nurse

leadership styles impact the process of professional integration of internationally recruited nurses. The few studies conducted in the UAE and other Gulf countries addressed the transcultural nursing skills and the general experiences of expatriate nurses as they integrated into the host society (Al Mutairi et al., 2013; El Amouri & O'Neill, 2014). The role of nurse leadership styles on the professional integration of expatriate nurses needed to be explored so that measures could be put in place to ease the transition process.

Purpose of the Study

The specific purpose of this qualitative grounded theory study was to develop a theory that would help to understand or explain how nurse leadership styles and behaviors impact the professional integration of expatriate nurses as they transition into a multicultural work environment of the acute care hospitals of the UAE and GCC region. The general purpose was to provide knowledge on how health care organizations and other stakeholders involved in the migration of nurses can develop and implement structures and processes that would make the integration of expatriate nurses a positive experience. The study focused on how the leadership style of a nurse leader impacts her or his relationship with expatriate nursing subordinates, and subsequently the expatriate nurses' process of professional integration. The perceptions of followers contribute greatly to the understanding of leadership (Junker & van Dick, 2014). Nurse leaders in the current study included nursing unit managers, charge nurses, charge midwives, and nursing supervisors. Leadership styles were described as those actions and behaviors exhibited by the nurse leader that influenced others to do what needed to be done. The

process of professional integration was described as the transitioning and assimilation of an internationally educated nurse into the destination society.

Research Questions

In view of the lack of a theory that explains the dynamics between the nurse leaders' styles and behaviors and the professional integration of expatriate nurses, the main question was "What is the perception of the expatriate nurses on the effectiveness of a nurse leader's styles and behaviors within a multicultural work environment in which expatriate nurses are integrating into the workforce?" The subquestions were as follows:

RQ 1: What are the lived experiences of expatriate nurses in a new work environment?

RQ 2: What is the ideal multicultural work environment that would promote the professional integration of expatriate nurses?

RQ 3: What leadership qualities would enhance the integration of expatriate nurses?

RQ 4: What are the key roles of a nurse leader in the professional integration of expatriate nurses?

RQ 5: What are the general experiences of expatriate nurses as they integrate into the destination health care organization?

RQ 6: What specific interactions with nurse leaders impacted the expatriate nurses' integration process?

RQ 7: To what extent did the organizational cultural and structural factors influence the expatriate nurses' integration process?

Theoretical Foundation

Transition Theory

Meleis's (2010) transition theory offers a framework and perspective from which the changes people undergo can be studied (Kumaran & Carney, 2014). According to Meleis (2010), a transition is a change from one stable state to another, and Poronsky (2013) added that transitions act as an interlude between two phases of stability in a person's life. In the current study, transition theory was used to identify the factors that could hinder or facilitate the transition process of expatriate nurses in the destination country. Transition theory offers a holistic approach that covers a broad perspective of people's lives and environments in which change can occur, such as in their developmental stages; life situations; behavioral, physical, and psychological health; psychosocial aspects of life; and organizations associated with the individuals (Joly, 2015). Researchers and theorists have used transition theory to understand the type of transitions people go through, the patterns of those transitions, the conditions that affect the transition, measures that could be instituted to alleviate problems in the transitions, and the possible outcomes of the transitions (McEwen & Wills, 2014; Meleis, 2010).

Any process of change involves some degree of discomfort such as a change in identity due to migration, lack of adequate social support systems to deal with the change, integration of new knowledge and skills, learning new roles, and an incongruence between the prechange expectations and reality (Poronsky, 2013). Meleis's (2010) theory of transitions highlights the central role played by nurses in assisting individuals,

families, and communities to embrace the change and navigate it successfully. Transition theory is discussed in more detail in Chapter 2.

Full Range Theory of Leadership

The full range of leadership (FRL) model was developed by Bass and Avolio in 1994, who built on previous work by Burns (1978). Bass and Avolio's FRL consists of the transformational, transactional, and laissez-faire leadership. The model was used as a theoretical perspective to guide the study from a broad leadership perspective. The main theoretical propositions are that effective leaders do not use a single leadership style, but a combination of the three styles (Ryan & Tipu, 2013). Each of the three leadership styles is meant to strengthen other leadership styles weak or undefined areas (Antonakis & House, 2014). The FRL served as a benchmark and backdrop for the leadership styles that were examined and explored in the current study. A more detailed description of the FRL model is provided in Chapter 2.

Conceptual Framework

The purpose of grounded theory is to develop a description and theory that explains the interactionary processes under investigation. Corbin and Strauss (2015) contended that because grounded theory aims at generating a theoretical explanatory framework, a researcher should not use an a priori theoretical framework. Charmaz (2014) pointed out that qualitative researchers do not come to the research situation tabula rasa, but rather bring with them some preknowledge and ideas about the phenomenon of interest. Corbin and Strauss (2015) added that a researcher could compare his or her new theory to an existing theory after data analysis. If necessary, the

generated theory could be compared to the concepts and constructs that make up the full range of leadership model (Bass & Avolio, 1994) and Meleis's (2010) theory of transitions. Theory, however, can also be used in research studies as a philosophical orientation, a guiding framework, or conceptual framework (Maxwell, 2013).

Grounded theory research focuses on actions and social processes (Charmaz, 2014), and these concepts were part of the phenomenon of interest in my study on leadership styles and the integration process of expatriate nurses. Grounded theory is considered a co-construction between the researcher and the researched of the interpretations of the interactions of the research participants and their environment or situation (Charmaz, 2014). Charmaz (2008) added that the grounded theory design helps researchers understand individuals' social constructions, and the research process emerges from interactions among the researcher, participants, and their life circumstances. In my study, I used constructivism and symbolic interactionism as the theoretical perspectives. A more thorough explanation of the conceptual framework is provided in Chapter 2.

Constructivism

The theoretical perspective of constructivism posits that humans interpret and construct reality according to their interaction with their life circumstances (Crotty, 1998). In other words, constructivism is the process of making meaning between human beings and their world. By extension, constructivism leads to different interpretations of reality, or the relativist ontology. Crotty (1998) highlighted that constructivism is synonymous with the concept of intentionality, which refers to the relatedness and

referentiality of humans and their worlds. In contrast to the objectivist epistemological stance, the researcher and participants in constructivist studies construct the data together, and the researcher is an active part of the research process bringing prior knowledge and theories to the study (Charmaz, 2008). The interaction between the researcher and participants produces the data. Higginbottom and Lauridsen (2014) referred to this interaction and data generation process as the researcher's construction of the participants' constructions.

Symbolic Interactionism

Symbolic interactionism is a theoretical perspective and school of thought that contains certain assumptions, including humans live in a symbolic environment, interpret each other's conduct or actions to make meaning of their surroundings and interactions, and respond accordingly (Charmaz, 2014; Handberg, Thorne, Midtgaard, Nielsen, & Lomborg, 2015). Symbolic interactionism posits that people's worlds contain objects or symbols that can be physical or abstract, and these objects are products of symbolic interaction (Blumer, 1969). Oliver (2012) added that the meanings that individuals construct from their social interactions with others shape self and behavior and influence the individuals' optimistic or pessimistic outlook toward the situation. Through a process of interpretation, the individuals making meaning have to identify what they are acting to or interacting with, and then iteratively embark on meaning making (Blumer, 1969). This theoretical perspective applied to my research topic, which addressed how leadership styles influence the process of professional integration of expatriate nurses into the host society. According to the symbolic interactionist paradigm, the expatriate nurses are

objects interacting with other objects, that are nurse leadership styles and behaviors, and are indicating and interpreting the developing actions (Blumer, 1969).

Nature of the Study

In the current study, I sought to explore the impact of nurse leadership styles and behaviors on the professional integration process of expatriate nurses who came for the first time to the United Arab Emirates within the preceding 12 months from their home countries. The UAE and other GCC countries such as Saudi Arabia have grown rapidly in the past few decades, and hospitals have been among the infrastructure resulting from the large-scale expansion (Al Yateem et al., 2015). This economic growth has exceeded the population growth, and the UAE has had to import expatriate workers to remedy the human resource shortages (El Amouri & O'Neill, 2014; Al Yateem et al, 2015). Foreign workers, including nurses, make up about 80% of the workforce in the UAE (Bealer & Bhanugopan, 2014). The UAE recruits nurses from all over the world, but 50% come from India and the Philippines (Al Yateem et al., 2015; El Amouri & O'Neill, 2011). The rest of the nurses come from countries such as the United Kingdom, Australia, Canada, Iran, Jordan, Nepal, Sri Lanka, South Africa, Nigeria, Kenya, Poland, France, and South Korea. Nurses are responding to the global market demands and the attractive employment packages offered by the strong economies of the UAE and other GCC countries to ensure a steady and ample supply of expatriate nurses (Almutairi et al., 2013; Al Yateem et al., 2015; Bealer & Bhanugopan, 2014). No statistics are available on the exact number of expatriate nurses who leave their employment within the first 2 years due to issues with professional integration and assimilation into the host society, even

though most hospitals in the UAE have 2-year renewable contracts for expatriate nurses, per the labor laws. The similarities among the GCC countries could enable generalizability and transferability of the study findings across the region.

The research sample was drawn from two acute care hospitals in the UAE. The naturalistic paradigm was used to elicit the perceptions of the expatriate nurses regarding how the nurse leader styles and behaviors impacted their professional integration. Qualitative research has social constructionist and interpretivist philosophical underpinnings, where research participants describe their world according to how they interpret it (Denzin & Lincoln, 2007; Maxwell, 2013). Constructivist grounded theory as described by Charmaz (2014) was used to explore the impact nurse leaderships styles and behaviors had on the expatriate nurses' integration into the destination society. The grounded theory design is the ideal strategy of inquiry when there is very little known about a phenomenon, because it is exploratory in nature (Maz, 2014; Patton, 2015). The study participants were asked to describe their interactions with the nurse leaders and to give their perceptions of how this interaction influenced their integration into the new work environment. The intent of grounded theory research is to understand the interactions, behaviors, and meanings that individuals give to their experiences of phenomena or situations (Giles, de Lacey, & Muir-Cochrane, 2016).

Purposeful quota sampling was used to identify an information-rich homogenous sample, and eight expatriate nurses were used in the initial data collection phase; the sample size changed as the study progressed (see Patton, 2015; Robinson, 2014). Triangulation was used to collect thick data and to maximize the confirmability of the

research findings (see Miles, Huberman, & Saldaña, 2014). To enhance trustworthiness of the data, data source triangulation was used to collect data from two acute care hospitals in the UAE. Method triangulation, involving in-depth individual interviews and document review, and data type triangulation involving textual and audiovisual data in the form of documents, were also used (see Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014; Miles et al., 2014). An interview protocols was used to guide the semistructured interviews. Demographic surveys were used to screen the potential participants for inclusion criteria such as the years of nursing experience and whether this was their first time in the UAE.

In constructivist grounded theory, the researcher is a part of the research situation. To minimize researcher bias, researcher reflexivity is used to acknowledge the researcher's position in the research situation and previous experience with the phenomenon of interest (Charmaz, 2014). In the current study, data were analyzed using the constant comparison method through initial line-by-line coding and then gradually building up to focused, axial, and theoretical coding. The data were then used to derive codes and categories, as well as to explain the relationships between the emergent categories, as espoused by Charmaz (2014). Concurrent data collection and analysis stopped when data saturation was reached. The computer-based data analysis software package NVivo was used to organize the data during the data collection and analysis phase.

Definition of Terms

Destination countries: Recipient countries, predominantly the developed countries that recruit and employ nurses educated in other countries to redress nurse shortages (Li et al., 2014).

Donor countries: The source countries, usually the developing countries from which nurses migrate to the recipient countries for work purposes (Walani, 2015).

Expatriate nurses: Nurses who leave their native countries to work and settle in another country. The term expatriate nurses was used synonymously with internationally educated nurses and immigrant nurses in the current study.

Internationally educated nurses: Nurses born and educated outside the country to which they migrate and transfer their status as professional nurses (Walani, 2015). In the current study, internationally educated nurses were synonymous with expatriate nurses.

Multicultural work environment: A work environment in which employees have diverse cultural and linguistic backgrounds (Nichols & Cottrell, 2014). This is the status quo in the health care organizations in the UAE, where both the health care professionals and health care consumers come from different countries.

Nurse leadership styles: Leadership styles are methods by which nurse leaders and other leaders direct, motivate, and guide subordinates toward the achievement of organizational goals; the actions exhibited and used by nurse leaders to influence their subordinates (Arnold et al., 2015).

Professional integration: The process through which professionals such as nurses become members of a new professional group in a host organization, and get to use their

professional skills towards reaching that group's goals (Covell, Neiterman, & Bourgeault, 2016). The professionals undergoing the integration may have to unlearn aspects of their original professional culture and learn a new one, in what is referred to by Neiterman and Bourgeault (2015b) as professional resocialization. Professional integration may lead to the development of a new professional identity concomitant with the host society.

Transition process: The process in which the newly arrived nurses adjust to the host health care context and adopt the cultural norms of the health care organization (Neiterman & Bourgeault, 2015b).

Transnational nurse migration: Movement and relocation of nurses across international boundaries in response to push and pull factors such as better life prospects, global shortage of health care professionals, political instability, changes in nurse status, and career opportunities (Prescott & Nichter, 2014).

Assumptions

The assumptions for the study were that the study participants would be truthful in their descriptions of their experiences regarding nurse leaders' styles during their integration into the host society, and could remember their experiences within their first year of arrival to the UAE. Another assumption was that the research findings would be transferable to other GCC countries in view of their cultural and religious similarities. I also assumed the purposeful sample would be a rich source of information that would yield deeper understanding of the phenomenon of interest and also lead to the generation of a theory that would explain the role nurse leadership styles play in the professional integration process of expatriate nurses. My final assumption was that the grounded

theory approach was the best method for satisfying the study's objective of exploring the different perceptions of leadership influence on the integrating expatriate nurses.

Scope and Delimitations

The study focused on the influence of nurse leaders' styles and behaviors on the professional integration process of expatriate nurses who migrated to the United Arab Emirates during the previous year. This phenomenon was selected because migrating nurses have been found to experience considerable difficulties during their transition into the new work environment (Walani, 2015), and nurse leaders play a crucial role in regulating the work atmosphere, staff motivation, and job satisfaction of nurses (Zampieron, Spanio, Bernadi, Milan, & Buja, 2013). Al Yateem et al. (2015) and Almutairi et al. (2013) found that because the GCC countries shared similar backgrounds and functions, nurses in both the UAE and Saudi Arabia experienced similar acculturation and integration issues.

There are expatriate nurses in most of the health care institutions in the UAE, and these nurses make up about 80% of the nursing workforce (El Amouri & O'Neill, 2011). This study was delimited to expatriate nurses in acute care hospitals only. In addition, only expatriate nurses within 1 year of arrival to the UAE were included in the study. The rationale was that expatriate nurses faced integration challenges during their first year of transnational employment (Xiao et al., 2014). The participants represented a mixture of genders and nationalities. Quota sampling strategy (Robinson, 2014) was used to recruit study participants to ensure that the major migrant nurse donor countries were represented in the sample to maximize the potential for transferability of study findings.

Limitations

The small sample size associated with the qualitative research paradigm has the potential to limit the generalizability of research findings, but the small homogenous samples in qualitative studies are information rich and provide richer, deeper data. Generalization of the research findings would apply to the GCC region only because these countries are unique in that they have expatriate employees who outnumber local employees (Al Yateem et al., 2015; El Amouri & O'Neill, 2011). Collecting data in the participants' naturalistic environment could involve bias resulting from the Hawthorne and reactivity effects (Grove, Burns, & Gray, 2013). Both constructivism and symbolic interactionism have subjectivist underpinnings, which could affect the dependability of the findings because the participants reported their experiences and made meaning of their perceptions of leadership styles. The findings could also be limited by researcher bias because I am an expatriate nurse. Reflexivity through researcher memos was used to minimize researcher bias. I acknowledged my previous experience with professional integration and prevented my preconceived ideas from influencing the interpretation of the data.

Significance of the Study

Expatriate nurses are expected to be culturally competent after a certain period of integration into the destination country (Garneau & Pepin, 2015). These nurses' experiences during the transition process have not been explored, although researchers have reported that individuals experience challenges during their integration into a new environment (El Amouri & O'Neill, 2014; Moyce et al., 2015). Leadership styles and

behaviors have also been documented as either promoting or inhibiting job satisfaction and staff engagement (Saleem, 2015). Understanding how nurse leaders' actions and behaviors promote or inhibit the smooth transition of internationally recruited nurses may contribute to the body of knowledge related to the phenomenon, and may also influence policy change and positive social change for the stakeholders.

Significance to Theory

Exploring the interface between the nurse leadership styles and behaviors and the expatriate nurses' integration process into new work environments may help generate a theory that may be used to alleviate the process of professional integration and facilitate smoother transition into a multicultural work milieu. The study could also contribute to the nursing leadership field through identification of more effective leadership styles that could ensure staff engagement, organizational citizenship behavior, and nurses' intent to stay in a multicultural working environment. In addition, the study could also provide greater insights into the interactions between nurse leadership styles and the integration of expatriate nurses.

Improving Practice and Policy

As more nurses migrate to the recipient countries, more effective solutions are required to address the challenges they encounter as they adapt to the professional environment in the host society. The expatriate nurses' perceptions and expectations may help stakeholders to develop policies and practices that may ease the transition process of these nurses. Orientation programs could be better aligned to redress specific challenges encountered by expatriate nurses. Nursing education standards and curricula in the donor

countries could be adapted to help prepare nurses to fit in easily into the destination health care organizations. Additionally, organizations could develop or adopt training programs for nurse leaders to be more effective in leading culturally diverse subordinates (Washington, 2015).

Implications for Social Change

Interventions designed to ease the transition process of expatriate nurses could lead to better coping mechanisms for the affected nurses, as well as less stress and better psychological and physical health. Counseling programs could be designed to help expatriate nurses cope with the different professional and cultural practices in the host society. The self-esteem and self-worth of the expatriate nurses could be enhanced, leading to higher motivation levels and ultimately a positive work environment and favorable patient outcomes. Transparency in transnational nurse migration regulation and policies may minimize unethical nurse recruitment practices from developing and resource limited countries.

Summary and Transition

The shortage of nurses in the developed world and the poor working conditions in the migrant nurse donor countries continue to encourage transnational nurse migration (Shaffer, Robinson, Dutka, & Tuttas, 2016). Although the experiences of expatriate nurses during integration into the destination society have been widely investigated, a lack of knowledge remains on how nurse leadership styles and behaviors impact the professional integration process of expatriate nurses, and how the behavior of nurse leaders influence the expatriate nurses' adaptation and assimilation into the host work

environment. The theoretical perspectives of constructivism and symbolic interactionism, and Meleis's (2010) theory of transitions, guided the constructivist grounded theory study to explore the expatriate nurses' professional integration as influenced by nurse leaders' styles and behaviors. Chapter 2 provides a more detailed review of the literature related to the key issues and gaps pertaining to this study.

Chapter 2: Literature Review

Most developed countries such as the United States, Canada, the United Kingdom, and Australia are facing a critical shortage of nurses and other health care professionals, and are redressing this gap by recruiting transnationally from places such as Asia, Africa, and Eastern Europe (Moyce et al., 2015; Timilsina Bhandari, Xiao, & Belan, 2015). Transnational migration occurs when an individual relocates to another country. Such forms of migration can include unique professional integration challenges as the individual adjusts and adapts to the workplace in the destination country. Many studies have been conducted to explore the experiences and challenges of the acculturating health care professionals (Alexis, 2015; Ho & Chiang, 2015; Wheeler, Foster, & Hepburn, 2013).

The documented experiences of expatriate nurses during professional integration included difficulties with professional registration and licensing, racism, discrimination, communication difficulties, lack of organizational support, nursing practice differences, de-skilling, inequalities and lack of egalitarianism, social exclusion, and cultural differences (Alexis, 2015; An, Cha, Moon, Ruggiero, & Jang, 2016; Primeau et al., 2014). Al Yateem et al. (2015) and Almutairi et al. (2013) mentioned the Muslim culture as posing significant challenges for the expatriate nurses, even though the UAE and other GCC countries recruit predominantly from India and the Philippines, which have Muslim communities of their own. Cultural competence is cited as a requirement for quality patient care and the prevention of health disparities, and the expatriate nurses may be expected to exhibit such skills even though traditional nurse education does not prepare

nurses for cultural challenges (Al Yateem et al., 2015; Kumaran & Carney, 2014). Few studies addressed the impact of leadership styles and behaviors on the integration experiences of expatriate nurses. The cultural competence levels of the research participants may have influenced the study findings, regarding nurse leadership styles and behaviors. Leadership styles and behaviors exhibited by the nurse leaders have been found to have an impact on the general work atmosphere, as well as job satisfaction, psychological well-being, intent to stay, retention, engagement, and organizational citizenship behaviors of the subordinates or followers (Baysak & Yener, 2015; Saleem, 2015; Santos, Caetano, & Tavares, 2015). The expatriate nurses bring with them their own expectations and perception of leadership behaviors, which may be different from those of the destination health care organization.

The purposes of this study were to gain insights into how the leadership styles used by the leaders in the health care organizations in the recipient countries influence the integration process of the expatriate nurses, and to develop a theory that would explain the interactionary processes that occur during expatriate nurses' process of professional integration. An understanding of the interactionary processes between the migrant nurses' integration process and the nurse leadership styles could inform the policies, strategies, and interventions on the recruitment and integration of internationally recruited nurses and other health care professionals.

The literature review consisted mainly of resources from the Walden university library, Google Scholar, and the cited references in the bibliographies of reviewed articles. The referenced articles and articles from Google Scholar were then retrieved

from the Walden University library. Seminal literature resources such as monographs and research articles older than 5 years were also used.

Organization of the Literature Review

The purpose of this literature review was to examine and explore the current literature for information and insights on how the nurse leadership styles and behaviors impact the professional integration process of internationally educated nurses. This would help to identify any gaps in the literature that would justify the research study, and to gain a deeper understanding of what expatriate nurses experience during the process of professional integration. Insights into nurse leadership styles and behaviors would give a basis for conducting the study and for the potential influence on global policy change that could ease the process of migration and acculturation for the expatriate nurses.

In this chapter, I describe the literature search strategies and the literature of grounded theory studies. This is followed by a review of the theoretical foundation, the conceptual framework, and a review of the literature related to the professional integration process of internationally recruited nurses, including the definition, causal or push and pull factors of nurse migration, transition experiences, the potential impact on the recipient health care organizations, and the impact of nurse migration on the donor countries. Finally, I present a review of the literature addressing the role of leadership styles on the work environment.

Literature Search Strategy

Professional integration in relation to nursing is a process through which the health care professionals are resocialized into the destination health care organization,

learn the new professional culture, and recreate their professional identity (Neiterman & Bourgeault, 2015b). Professional integration processes and mechanisms can also be seen in the social and behavioral sciences, for example with intellectually challenged individuals (Nicolae & Enikö, 2012). Nurses are not the only professional group that is responding to the globalization-related push and pull factors and migrating. Other health care professionals such as physicians and pharmacists are taking job assignments internationally (Alexis, 2015; Ho & Chiang, 2015).

The search for peer-reviewed journal articles was conducted primarily from a multidisciplinary perspective from the Walden University library through the following search engines: Academic Search Complete, ProQuest Central, Web of Science, ScienceDirect, PsychINFO, CINAHL, MEDLINE, Business Source Complete, PubMed, and SocINDEX. Reference articles identified through Google Scholar were then accessed through the Walden University link facility. The references selected for the literature review were not more than 5 years old, but in a few cases, seminal articles were used even though they were older. Search terms included *internationally educated nurses*, *immigrant nurses*, *expatriate nurses*, *nurse migration*, *foreign-educated nurses*, *migrant nurses*, *professional integration*, *integration process*, *acculturation process*, *leadership styles*, *leadership behaviors*, *work environment*, *multicultural work environments*, *cross-cultural leadership*, and *global leadership*. Some references from the references were also searched if they were found to be relevant to the proposed study.

Literature Use in Grounded Theory

Grounded theory studies are conducted to discover, generate, or develop a theory from the emerging data (Charmaz, 2014). A priori literature review in grounded theory helps the researcher to have an idea of what theories have been generated in relation to the phenomenon of interest (Howard-Payne, 2016). By extension, conducting a literature review provides background information on the phenomena under study, helps to justify the study, informs the development of the research questions, and helps grounded theory researchers to avoid reproducing existing theories (Howard-Payne, 2016). Classic Glaserian grounded theory, however, advocates for conducting a literature review after data collection to avoid tainting the emerging theory with preconceived ideas (Maz, 2013). In this constructivist grounded theory study, the preliminary literature review was intended to (a) identify previous research that addressed professional integration of nurses, and how this process was influenced by nurse leadership styles; (b) highlight the contextual and cultural factors that influence the expatriate nurses' perception of nurse leadership actions; (c) provide justification for the constructivist epistemological stance; and (d) outline potential implications for organizational and patient outcomes in relation to the internationally recruited employees' psychological well-being.

Theoretical Foundation

Transition Theory

The primary theoretical foundation for this study was Meleis's (2010) transition theory due to its multidimensional nature and its applicability across a variety of changing life situations. Transition theory has been used broadly across situations in

which individuals, families, and communities have undergone certain changes in their life situations (McEwen & Wills, 2014; Meleis, 2010).

Origin of the transition theory. Meleis's (2010) interest in transitions began in the 1960s when she was involved with support groups seeking to assist individuals and families to deal with a variety of life changes such as diagnosis with chronic illness or having a baby. This experience coincided with the period when there was a growing interest in theory development in the United States, and transition theory was reinforced by Meleis's nursing background. Issues such as what would happen if individuals failed to have a healthy transition and the nurse's role in clients' transitions, concept analyses, and literature reviews led to the development and evolution of the transitions theory over four decades (Meleis, 2010). Meleis included input from some of her colleagues.

Major theoretical propositions. The transition theory is a middle range nursing theory that is used to describe the experiences of individuals when changes occur in their lives, and suggests that nurses have a key role in the experiences of people as they undergo changes in their lives (Joly, 2015). Meleis (2010) described her theory as a work in progress, and the current version describes four categories of transitions in which nurses can be involved: developmental, situational, health-illness, and organizational transitions.

Developmental transitions. These are transitions related to biological stages of growth such as the birth of a new baby, adolescence, adulthood, retirement, and menopause (Meleis, 2010).

Situational transitions. Changes in family situations such as divorce, becoming

homeless, changes in professional and educational roles, migration to other places, and moving to a nursing home are examples of situational transitions (McEwen & Wills, 2014; Meleis, 2010).

Health-illness transitions. Examples of health-illness transitions include cancer diagnosis, amputation of body parts, recovering from an illness, and discharge from the hospital (Meleis, 2010).

Organizational transitions. These refer to changes in the environment that pertain to nurses, which may be due to political, social, or economic factors and may result from changes in the organizational structure of culture (Meleis, 2010).

Other key concepts of the transitions theory are patterns of transitions such as whether the transition is single, multiple, or sequential, and properties of transitions that describe the transition experiences such as engagement (Meleis, 2010). The transition conditions either facilitate or hinder transitions, and personal factors (cultural significance, beliefs, values), community, and social factors such as social relationships and the patterns of response to the transitions are part of the transitions theory (Mora-López, Ferré-Grau, & Montesó-Curto, 2016). Finally, nursing therapeutics denote the roles played by nurses in the transition experiences of patients (Meleis, 2010).

Rationale for selecting the theory of transitions. Transnational nurse migration involves movement of nurses from one country to another, and the transplantation of nurses from the home country to the destination country social and work culture (Neiterman & Bourgeault, 2015b). Transition is defined as "the passage from one state, stage, subject, or place to another" (Ladores, 2015, p. e120). Expatriate nurses embark on

a transition when they migrate to other countries. The constructs and concepts that make up the theory of transition align with the migration process of expatriate nurses as well their integration experiences and outcomes.

Relation to expatriate nurses' professional integration. Meleis (2010) described transnational migration as a complex situational transition that involves radical changes in individuals' lives, where disconnections from previous social associations occur. Additionally, the transition conditions (facilitators and inhibitors of transitions) are related to the experiences reported by expatriate nurses during their process of integration in the destination countries. The concept of nursing therapeutics in the transitions theory refers to the actions performed by nurses to prepare the clients for the transition (Meleis, 2010). In the current study, the organizational culture and the leadership styles and behaviors symbolized the nursing therapeutics. Expatriate nurses undergo professional resocialization to fit into the new professional culture (Neiterman & Bourgeault, 2015b). Similarly, Meleis (2010) asserted that nurses go through professional socialization as they transition from one phase of professional status to another.

Application of transitions theory in literature. Meleis's (2010) theory of transitions continues to gain popularity and has been used widely to frame studies exploring different transitions (McEwen & Wills, 2014). Transition theory has been used to guide studies on developmental transitions such as first time parenthood. Entsieh and Hallström (2016) found that educational preparation such as antenatal classes facilitated the transition conditions. Adolescence, which is another aspect of developmental transitions, was explored by Ladores (2015) and Joly (2015). The adolescent child

transitioned from pediatric to adult health care and recommended transition planning to ease the process for the adolescent patients. Joly (2015) specified that the adolescent patients and their families struggle to navigate the adult health care system.

Nursing research on transitions has focused more on situational transitions in the form of role transitions from one status to another, for example from student nurse to staff nurse (Kumaran & Carney, 2014), from registered nurse to nurse practitioner (Poronsky, 2013), from registered nurse to nurse educator (Goodrich, 2014), and transitions of international nursing students (Vardaman & Mastel-Smith, 2016). These studies indicated that (a) individuals engaged in a transition must be aware of the knowledge and skills necessary for a successful transition, and must reach out to social and community support systems; (b) faculty should prepare nurses for the transition period; (c) preceptorship, mentorship, and orientation programs facilitate transitions; (d) transition planning promotes healthy transitions; and (e) transition processes should be evaluated on a formative basis to encourage healthier transitions.

Health-illness transitions are exemplified by studies conducted among patients discharged from intensive care units and stepping down into general wards (Ramsay, Huby, Thompson, & Walsh, 2014), and caregivers of patients diagnosed with a chronic condition (Mora-López et al., 2016). These studies highlighted the fact that the patients and their families experienced distress, fear, and uncertainty and derived psychological support from the nursing therapeutic ministrations such as health education and counseling.

Dowling and Melillo (2015) examined organizational transitions in a study of departments that changed to nursing schools to alleviate the nursing shortage, and noted that although the outcome was the attraction of skilled faculty to the schools, lack of support from the authorities inhibited successful transitions.

Full Range of Leadership Model

Although the primary theoretical foundation for this study is the theory of transitions, the transition process of expatriate nurses was explored against the impact of leadership styles exhibited by the nurse leaders in the new workplace. Leadership regulates the work environment (Girdauskiene & Eyvazzade, 2015). The Institute of Medicine (IOM) report, *Keeping patients safe: Transforming the work environment of nurses* identified problems concerning work practices, work environment, and organizational culture. One of the recommendations the IOM suggested to address these problems was the establishment of responsive leadership (Blake, Leach, Robbins, Pike, and Needleman, 2013). One of the responsive leadership theories used most frequently and most researched in leadership studies is Bass and Avolio's (1994) full range leadership (FRL) model.

Rationale for the Choice of Theory

In this study I sought to explore the interactions between expatriate nurses and their nurse leaders, and the full range leadership model focuses on the relationship and interaction between leaders and followers (Luo, Wang, & Marnburg, 2013). The phenomena under study were the positive and negative experiences of expatriate nurses in the host culture. The full range leadership theory was the ideal vehicle for this study as

it focuses on both the positive and negative effects of leadership styles encompassed within transformational, transactional, and laissez faire leadership styles (Samad, Reaburn, Davis, & Ahmad, 2015).

In response to critique concerning the applicability of the FRL model across cultures, the theory proponents stated that the leadership model could be used in collectivist cultures such as those found in Asia, although the FRL model was initially developed and tested in individualistic cultures such as the US and Europe (Luo et al., 2013).

Relation of the FRL Model to the Current Study

The FRL model related to this study in that it offered a range of leadership theories and leadership behaviors, whereas other leadership theories were singular. Using a single theory would have limited the scope of the leadership behaviors and traits with which the expatriate nurses were interacting. Transformational leadership is a form of supportive leadership and emphasizes leader-follower relationships, interactionary processes, and organizational outcomes (Arnold et al., 2015). This aligned with (a) the philosophical perspective of symbolic interactionism, that also focuses on interactions (Blumer, 1969), (b) studies in which expatriate nurses cited support and the lack of support as facilitating or hindering integration into the host culture (Li et al., 2014), and (c) organizations that went on recruitment drives and ensured programs were in place to help expatriate nurses to integrate, assimilate into, and be retained in the recipient organizations (Ho & Chiang, 2015).

Finally, one research question was designed to address perceived leadership qualities that would impact professional integration. In addition, the nine factors that are the measurable constructs of the FRL model provided several leadership qualities from which the research participants could derive answers. The nine constructs in the FRL model included both positive and negative leadership behaviors, which would have been experienced by the expatriate nurses (Ryan & Tipu, 2013). Another research question investigated the role of the nurse leaders in the professional integration of expatriate nurses, and this guided the broad range of roles of leadership encompassed in the FRL model.

Origins of the Full Range of Leadership Model

In 1985, Bass and Avolio investigated the two leadership styles described by Burns in 1978, and concluded that transformational and transactional leadership styles were complementary, effective and relevant to organizations (Bass & Avolio, 1994). After several research studies laissez-faire leadership was later added, and together, the three dimensions formed the full range of leadership model. The full range leadership model assumes that followers perform better when they have a transactional relationship with the leader, but rewards alone are not effective, therefore the leader needs to use transformational leadership behaviors to inspire high achievement, motivation, and commitment among followers (Antonakis & House, 2014). The current form of the full range of leadership model consists of the transformational leadership theory, the transactional leadership theory, and the laissez-faire leadership theory (Luo, Wang, Marnburg, & Øgaard, 2016).

Measurement Constructs of the FRL Model

The full range of leadership model has nine factors that are used to measure or rate attributes, behaviors, and characteristics of leaders utilizing any style from the plethora of leadership styles encompassed in the leadership model (Luo et al., 2016). These nine factors are derived from the three leadership styles making up the full range of leadership model. Transformational leadership has four main domains, as mentioned earlier, inspirational motivation, idealized influence, intellectual stimulation, and individualized consideration (Antonakis & House, 2014). Idealized influence is broken down into two factors, that is, idealized influence (attribute), which incorporates role modeling in morals and values, and idealized influence (behavior), in which the leader inspires the attainment of goals (Luo et al., 2016).

Transactional leadership contributes to the construct's contingent reward, management by exception active, and management by exception passive, and the final measurable construct is factor is laissez-faire (Luo et al., 2013). These constructs are measured using tools such as Bass and Avolio's (2004a) multifactor leadership questionnaire (Ryan & Tipu, 2013). This tool is a Likert-type and requires participants to rate the nine constructs from a range of 0 to 5.

Literature Related to Application of the FRL Model

The full range of leadership model has been used broadly in different contexts where leadership occurs, which include nursing, religion, organizational psychology, education, banks, hotels, the military, other business institutions (Luo et al., 2013). The majority of the studies on FRL used the quantitative research approach to be able to

measure the constructs of FRL using the questionnaire designed by the proponents of the FRL model (Bass & Avolio, 1994). Ryan and Tipu (2013) tested the FRL model for its effect on innovation in a non-Western culture in Pakistan, and also sought to determine if the leadership model could be transferred to other cultures. The study by Ryan and Tipu (2013) is similar to the current study in that both deal with cultural differences. In a similar study, Luo et al. (2013) found that the individualistic nature of the FRL model rendered it inapplicable to the generally collectivistic culture of China. This finding applied to the current study, because the transnational nurse migration trend in the United Arab Emirates was such that the majority of nurses came from Asian countries such as India, the Philippines, and Africa (see El Amouri & O'Neill, 2014). These countries are predominantly collectivist cultures, whereas most of the nurses in leadership positions in the UAE are Western and individualistic (El Amouri & O'Neill, 2014).

Nations and health care organizations have enacted policies and programs to facilitate recruitment, employment, and retention of expatriate nurses, with the strategic goal of stimulating employee engagement and reducing turnover (Covell et al., 2015). The studies by Arnold et al. (2013) and Samad et al. (2015) addressed the influence of the FRL model on employee wellbeing, burnout, and stress; and the findings supported the hypothesis that some domains of the FRL promoted job satisfaction and staff retention. Similarly, Guay and Choi (2015) found that the FRL fostered organizational citizenship behavior; and that the quality of the leader-member exchange relationship depended in part on the follower personality, characteristics, and other factors including culture and socialization.

In contrast, other researchers found shortcomings and weaknesses with the FRL model and offered suggestions for improvement and strengthening the weak areas. For example, Antonakis and House (2014) contended that transformational and transactional leadership styles did not enable adaptation to threats to the external environment or dealing with complex issues. The phenomena of interest in the current study included complexes like professional resocialization, cross-cultural leader-member exchange relationships, changing organizational demographics, and the problems associated with integration into a new culture. According to Antonakis and House (2014), leaders should not only focus on influencing followers to achieve revolutionary goals, but should also develop instrumental leadership skills that pertain to expertise at forming strategies for dealing with complex matters.

Conceptual Framework

The conceptual framework that underpinned the current study was a combination of two philosophical stances that guided the study, content focus, and framed the context of the inquiry. I reviewed literature on symbolic interactionism and constructivism to explore how the two theoretical perspectives would influence this study's methodology.

Constructivism

There are conflicting ideas of constructivism described in literature, but constructivism, according to Charmaz (2014) is a social science perspective that posits from relativist ontology that humans subjectively interpret the world around them and then construct reality. Ward et al. (2015) explained that the reality or constructions could be knowledge, facts, or things, such as theories in grounded theory studies. McWilliams

(2016) added that the construction of knowledge and reality were not static, but occurred in a context that was constantly changing. Constructivism was used to frame dialectical and hermeneutic studies that address the lived experiences of individuals (Lincoln & Guba, 2013). According to Raskin (2012), hermeneutic constructivist theorists asserted that reality and those creating it were interdependent, and rejected the notion that reality existed outside of those creating it. Peters, Pressey, Vanharanta, and Johston (2013) referred to constructivism as a research tradition; and elaborated that a research tradition was a research approach that had evolved to contain its own ontology, epistemology, and methodology for scientific inquiry.

Some social scientists used constructivism and constructionism interchangeably, but other researchers argued that the two concepts had different meanings. Hyde (2015) for example, stated that constructivism was a process in which knowledge was constructed on an individual level, whereas constructionism pertained to social participation. Ward et al. (2015) explained that constructivism was derived partly from learning theories developed by Piaget and Vygotsky, and placed an emphasis on knowledge synthesized by an individual. Conversely, constructionism was found to denote that reality and knowledge were constructed from a shared perspective by a group of people sharing commonalities. Ward et al. (2015) also noted that Charmaz (2014) used the terms constructivism and constructionism synonymously, depending on the situation and context. In contrast, Castelló (2016) stated that constructivism and constructionism were related concepts and should be used together in studies and interventions. Castelló

(2016) substantiated their argument by citing research studies that bridged the two concepts.

Some scholars of constructivism have begun to critique the trueness of other constructivists. For example Baerveldt claimed that constructivist thinkers tended to forget their place in the classic constructivist stream developed by Piaget, Vygotsky and others, and slid into objectivism. Other scientists proposed combining constructivism with other theories to strengthen perceived weaknesses. Raskin (2012) suggested adding the evolutionary epistemology to derive evolutionary constructivism that was perceived to be a better fit in psychology. McWilliams, on the other hand, proposed strengthening constructivism by integration with new generation pragmatism.

Symbolic Interactionism

The philosophy of symbolic interactionism, informed by the pragmatist philosophy, was first accepted by George Mead, given the name by Herbert Blumer, and often encompassed in theories underpinning qualitative studies (Handberg et al., 2015). Blumer placed symbolic interactionism in an interpretive paradigm arguing that human beings made sense of their surroundings based on what that meant to them (Blumer, 1969). Constructivist grounded theory has also espoused symbolic interactionism (Charmaz, 2014). The symbolic interactionist perspective has emphasized making of meaning, interpretation of symbols such as language, social interactions and processes, and perception of the self; and that reality was culturally constructed (Gallant, 2014). In addition, Hall et al. (2013) posited that symbolic interactionism helped to explain how individuals interacted with and understood their world. In a study to explore the role of

symbolic interactionism on preceptorship, Carlson (2013) agreed with Blumer (1969) that human beings were active participants in their interactions with their environment and response to stimuli. According to Carlson (2013) humans created meanings out their worlds by reflecting on their previous experiences. This premise aligned with Charmaz's (2014) constructivist stance that the researcher and the researched did not come to the research situation as blank slates with regards to the phenomena of interest.

Glaser maintained that grounded theory could be used in qualitative research outside the theoretical lenses of symbolic interactionism (Corbin & Strauss, 2015). Handberg et al. (2015) supported this assertion and posited that the tight link between grounded theory and symbolic interactionism could be untangled through critically identifying research situations in which symbolic interactionism could add value to studies without using grounded theory. There was evidence of studies that used symbolic interactionism as the framework guiding studies outside the grounded theory tradition. For example, Zhou (2014) used symbolic interactionism as the lenses through which the research design and research questions were framed to explore the lived experiences of China-educated nurses working in Australia. Carlson (2013) and Gallant (2014) also used symbolic interactionism on its own to inform their qualitative studies.

Introduction to Professional Integration Studies

Professional integration has begun to raise an interest among nurse researchers, but it was not a new phenomenon and has been explored considerably in the social sciences and rehabilitation of individuals (Nicolae & Enikö, 2012; Phan, Banarjee, Deacon, & Taraky, 2015). Neagu (2015b) contended that although the concept

professional integration was first described in the early 1970s, there was still a lack of consensus on the precise definition among researchers and social scientists. For the purpose of this study, professional integration was defined as a process through which professionals were introduced to a new society and assimilated into that society over time (Neiterman & Bourgeault, 2015b). Nicolae and Enikö (2012), however, described professional integration as training of individuals with Down syndrome with the aim of integrating them into society as productive members. It should be emphasized that professional integration was not a one-off event, but rather a process that occurred over a period of time (Neagu, 2015b). In spite of the growing interest in professional integration of nurses, there was very little research that had been conducted on the concept.

Approaches to the Study of Professional Integration

The growing interest in professional integration in different fields beyond health care, such as psychology (Neagu, 2015) and migration studies (Phan et al., 2015), has contributed to the emergence of many approaches to scholarship on professional integration. Professional integration has been described differently among the disciplines conducting studies on the subject. Some researchers referred to professional integration in the context of integrating patient care protocols (van Rensburg & Fourie, 2016). In this study, I discussed professional integration of nurses, professional integration in the form of rehabilitation, and professional integration of other migrant workers.

Professional Integration of Expatriate Nurses

Professional integration of expatriate nurses has been described as a process of adaptation into the host nursing workforce, where the expatriate nurses learned and

internalized the professional culture of the host country (Neiterman & Bourgeault, 2015b). Moyce et al. (2014) observed that there were different definitions of professional integration, but the concept generally referred to the result of a professional person meeting all the requirements of the new culture, and adapting and assimilating into the host workforce. The process of professional integration of nurses could be challenging, according to Neiterman and Bourgeault (2015a), who explained that nursing was inherently gender-based and the majority of nurses were females; and that made them an easy target for discrimination and bullying. Additionally, nursing was considered a lower professional status and nurses were more prone to unfair treatments in the destination countries (Neiterman & Bourgeault, 2015a).

Moyce et al. (2014) found in their integrative review that healthcare organizations used expatriate nurses to develop new clinical practices and techniques, while remedying the need for nurses by the local communities. The expatriate nurses on the other hand regarded the integration process as a trade-off for a rewarding future and new professional identity (Moyce et al., 2014). Neiterman and Bourgeault (2015b) contended that professional socialization did not pertain to newly graduated nurses who had to adapt to life as professional nurses, but expatriate nurses needed to be considered the same with regards to the different nursing practices between the donor and destination countries.

Most research on professional integration of nurses emphasized the inferior professional roles that were given to professional nurses. However, Neiterman and Bourgeault (2015b) noted that internationally recruited midwives enjoyed a more respectable professional status. Covell et al. (2016) discovered that some expatriate

nurses used alternative pathways such as becoming home caregivers to achieve professional integration when they encountered barriers. International nursing students also encountered similar challenges with integration as the trained nurses, and they needed to adapt to the teaching and learning methods in the recipient countries (Vardaman & Mastel-Smith, 2016).

Impact on organizational outcomes. Research studies on the influence of nurse migration and professional integration have focused mostly on cultural competence, culture congruent care, the financial burden of international recruitment and staff retention, and the creation of culturally diverse work environments. Expatriate nurse brought with them to the host country new ways of patient care, and also influenced the host nurses to seek ways to establish interpersonal relationship with them (Santy-Tomlinson, 2015). This placed on organizations the responsibility of ensuring that the care practices brought by the expatriate nurses were culturally competent and culturally safe for the patients in the recipient organization (Ohr et al., 2014). Sherwood et al. (2014) investigated the role played by expatriate nurses in ensuring patient safety, and found that despite having similar general nursing competencies with the local nurses, expatriate nurses showed different levels of cultural competence and cultural sensitivity that could lead to unfavorable organizational outcomes. Moyce et al. (2015) raised the concern that language barriers could lead to potential patient care errors such as incorrect transcribing of medication orders. Litigation could ensue, although this was not explicitly mentioned in the study.

Health care organizations made considerable investments in the international recruitment drive, programs and policies to ensure expatriate nurses integrated efficiently into the host workforce (Covell et al., 2016). Unfortunately, when the nurses arrived and found that their pre-arrival expectations did not match reality they could have decided to leave the organization, causing the organization to lose their financial investment (Buchan et al., 2015). Gao et al. (2015) added that the high turnover rates among expatriate nurses exacerbated the staff shortage situation and compromised patient care.

Impact on the work environment. Research evidence has shown that transnational nurse migration contributed to the creation of multicultural work environments (Moyce et al., 2015). Such culturally diverse organizational landscapes created the unique challenge of coordinating patient care and organizing employees in a heterogeneous organization. Xiao et al. (2014) also noticed that it was difficult to maintain collegial work relationships in such multicultural organizations. While investigating the educational and religious needs of expatriate nurses in the United Arab Emirates and Saudi Arabia, Al Yateem et al. (2015) found that most expatriate nurses were not from a Muslim background, and had very little knowledge of the Muslim culture. The main concern was that the Muslim patients under the care of these expatriate nurses would not receive care that was culturally congruent and the patients could be injured culturally (Al Yateem et al., 2015). The recommendation to the recruiting organizations was to provide adequate transcultural nursing orientation programs to the new nurses to protect the patients. This study by Al Yateem et al. (2015) had similarities with my study in that the setting and the sample were common. Al Yateem et al. (2015)

also explored the experiences of the expatriate nurses in the UAE, but did not address the influencing factor of nurse leadership styles.

Rehabilitation as Professional Integration

Professional integration has been discussed in relation to rehabilitation of individuals such as those with physical impairments and the socially marginalized. Neagu (2015b) observed that the main focus on professional integration was in relation with securing jobs for the youth. Additionally, integrating people into jobs was regulated by the availability of jobs and the prospective employee's fit with the available jobs. Nicolae and Enikö (2012), on the other hand, described professional integration as training of individuals with Down syndrome with the aim of integrating them into society as productive members. The justification for integrating people with Down's syndrome into professional jobs was that the affected individuals possessed enough faculties to be rehabilitated into productive members of society (Nicolae & Enikö, 2012). In this case professional integration implied that the process whereby people who had shortcomings, either physical, genetic, or social, were prepared for life in professional circles, and then transplanted into the appropriate occupations. This study by Nicolae & Enikö (2012) did not describe in detail how the preparations for professional integration were carried out, nor were the outcomes of the professional integration mentioned. Based on the findings from a study conducted in Portugal to evaluate the support systems for disabled people being integrated into the workforce, Filgueiras, Vilar, and Rebelo (2015) argued that disabled people could be helped to overcome their physical challenges by implementing adequate systems towards that cause. Additionally, the recommendations included

adaptation of the workplaces to accommodate the physically challenged employees. This study was also similar to the one conducted by Nicolae and Enikö (2012).

According to Opriș (2014), professional integration could be applied to the homeless people. Homelessness in this study was attributed to poverty, lack of affordable housing, and unemployment. The homeless were then equipped with skills for self-reliance and then assisted to enter the job market (Opriș, 2014). A parallel study in the European Union explored the policies informing and regulating the professional integration of young people into jobs, and found that the youth could not get jobs because there were very few jobs on the market, and there was competition (Neagu, 2015a).

Professional Integration of Immigrant Workers

Other professionals also migrated to other countries and social scientists were interested in learning their settlement experiences in the new communities. Phan et al. (2015) challenged previous research on the experiences of skilled immigrants in that the focus was only on gender roles and family investments; and proposed the inclusion of dynamics within the whole immigrant family. Phan et al. (2015) discovered that the absence of social network capital impacted negatively on the integration process of the immigrants. These findings were similar to the findings on the experiences of expatriate nurses in the host countries (see Xiao et al., 2014). The study by Phan et al. (2015) introduced the interesting dimension of altered gender roles where spouses of female immigrants took on the role usually assumed by the female immigrant in the home country. The nursing profession has been regarded as a predominantly female domain

and the spouses of the expatriate nurses may have to assume changes in gender roles in the host country.

Another factor affecting the professional integration of immigrants was acculturation. Immigrants brought with them their cultural orientations and traits such as religion, language and skin color to the new country, and these factors determined the type of acculturation they underwent in the new country (Kaplan & Chacko, 2015). In addition, Kaplan and Chacko (2015) found that the immigrants' socio-economic and legal status shaped their likely experiences and placed their identity in the new society. According to Kusek (2015) these acculturation challenges could cause the immigrants to fail to integrate completely into the new society, and to retain connection with their home countries. Expatriate nurses could also face similar challenges as they integrated into the host countries based on the current transnational nurse migration trend from poor countries to the developed countries (Walani, 2015). Transnational identity challenges were not only encountered by immigrants from backgrounds that were culturally different from the host country, as shown by Kusek's (2015) study on immigrants from the European Union who migrated to the United Kingdom.

Mediating Factors of Professional Integration

Although most researchers focused on the experiences of expatriate workers in the host countries, other researchers were interested in exploring the resources used by these individuals to facilitate successful integration. Malik, Cooper-Thomas, and Zikic (2014) noted that some expatriates fared better than others at integration and resocialization into the host society, and discovered that these individuals possessed

above average degrees of cultural intelligence (CQ). Another mediating factor of professional integration was the ability to effectively attain intercultural adjustment to the new culture (Huff, Song, & Gresch, 2014).

Cultural Intelligence

According to Malik et al. (2014), some individuals had an aptitude at forming trustful cross-cultural relationships in the host country, and seemed to have something that fostered intercultural adeptness. The authors identified that ability as Early and Ang's (2003) cultural intelligence. The construct of CQ is relatively new, but has attracted considerable attention among scholars from different disciplines, including organizational psychology, leadership, and migration (Şahin, Gurbuz, & Köksal, 2014). Cultural intelligence has been defined as the "… capability to adapt effectively in situations characterized by cultural diversity" (Huff et al., 2014, p.151). In agreement with this premise, Malik et al. (2014) asserted that individuals who exhibited higher levels of CQ could better understand the dynamics of a multicultural milieu, made efforts at adopting appropriate behavior, exercised cultural sensitivity (appreciation of other cultures), and effectively managed cross-cultural relationships. It was anticipated that cultural intelligence levels possessed by the expatriate nurses could facilitate smoother and easier acculturation into the host society.

In a study examining the relationship between expatriates' CQ and their experiences in the host country, Şahin et al. (2014) found that CQ was based on the situated learning theory, and exposed expatriates to different multicultural environments, and provided them with the context in which to practice and learn how to live in a

culturally diverse society. This finding concurred with Ho and Chiang's (2015) observation that the longer an expatriate nurse stayed in a recipient country the more their acculturation levels increased. CQ also carried implications for organizational outcomes, where an individual with high levels of CQ adapted successfully into the host organization and soon assumed the role of a productive member of the workforce (Malik et al., 2014). Additionally, Şahin et al. (2014) explained that cognitive CQ, motivational CQ, and behavioral CQ respectively enabled expatriates to actively seek to understand the values, norms, and cultural practices of the host society; to learn how to respond appropriately during intercultural interactions; and to be flexible towards their culturally diverse colleagues.

Intercultural Adjustment

Researchers agreed that expatriates underwent some changes as they transitioned and assimilated into new cultural contexts, and were expected to successfully adjust and integrate into their new workplaces in order fulfill their contractual obligations (Huff et al., 2014). Adopting a constructivist stance, Fee and Lu (2013) contended that expatriates adjusted to the new society by constructing meaning from the intercultural interactions to learn the ways of the locals, and then used this knowledge to change their practices to suit the new host society. Organizations were advised to provide orientation programs to assist the expatriates to adjust seamlessly into their new workplaces (Huff et al., 2014). In their longitudinal study, however, Fee and Lu (2013) challenged the trustworthiness of the findings from previous cross-sectional research studies on intercultural adjustment.

Literature Related to Challenges Faced by Expatriate Nurses

Despite migrating internationally in response to pull factors such as better professional prospects and better quality of life, expatriate nurses have reported experiencing significant challenges during their integration into the host nursing workforce (Likupe, 2015; Xiao et al., 2014). Although some research has found that internationally recruited nurses reported some positive integration experiences, the negative experiences were more profound and eclipsed the pleasant side of migrating (Likupe, 2015). The negative experiences included perceived active or passive discrimination, acculturation problems, communication challenges with colleagues and patients, frustrations with professional licensure procedures, feelings of isolation and loneliness, and exclusion and marginalization in the workplace (Ho & Chiang, 2015; Holmes & Grech, 2015; Li et al., 2014). In response to these integration problems, researchers have called for policy change at both national and international levels to alleviate the plight of expatriate nurses (Prescott & Nichter, 2014). Sherwood and Shaffer (2014) stated that it was the responsibility of the host country to provide the internationally recruited nurses with opportunities and resources to facilitate socialization into the workplace culture.

Perceived Discrimination

Discrimination is described as unequal treatment of individuals or groups. Walani (2015) stated that discrimination resulted when characteristics such as personal attributes, skin color, gender, and nationality determine employment outcomes, and added that discrimination was one of the most serious challenges that beguiled expatriate nurses.

Expatriate nurses perceived that they were discriminated against in the new workplaces, with non-Western nurses reporting more incidences of aggression, being passed over for promotion, getting jobs beneath their professional qualifications, and racist tendencies (Alexis, 2015; Walani, 2015). Conversely, their Western counterparts perceived less discriminatory actions due to some shared commonalities such as background. According to Nichols, Horner, and Fyfe (2015) expatriate nurses not only reported discrimination in the workplace, but were also discriminated against in the community at large, with skin color as the main determinant of discriminatory tendencies.

In an exploration of the role of expatriate nurses in a quality and safe workforce, Sherwood and Shaffer (2014) found that discrimination was not only meted out by the organizational culture, but that patients were also prejudiced against expatriate nurses based on cultural and language differences. Furthermore, Li et al. (2014) contended that the lack of clear policies informing the integration of internationally recruited nurses and double standards encouraged the discrimination of these nurses. In addition, the expatriate nurses reported unfair labor practices where expatriate nurses receive lower remuneration than their native counterparts, despite having worked the same shifts and hours (Li et al., 2014). Discrimination inevitably led to unhealthy and unproductive work environments, and ultimately, poor patient outcomes (Walani, 2015).

Barriers Related to Nurse Registration

Nursing skills could be transferred from one country to the other, but the recipient country required the internationally recruited nurses to meet certain criteria and credentialing to gain professional licensure to practice. This ensured the safety of the

health care consumers. Expatriate nurses have expressed their frustration at the lengthy and tedious process of nursing licensure (Sherwood & Shaffer, 2014). In addition, Ho and Chiang (2015) argued that the process of registration with professional bodies was expensive, complex, not transparent, and the internationally recruited nurses fumbled through the process. Furthermore, recruitment agencies facilitating the international recruitment process did not give the nurses full information on the process, document requirements, and licensing procedures (Moyce et al., 2015). Sometimes, immigrant nurses were so desperate to get a job and survive, they ended up accepting registration for lower professional status just to get visa sponsorship from prospective employers (Xiao et al., 2014). Expatriate nurses also faced delays with gaining professional nurse registration if they were required to undergo additional prelicensure training or bridging courses (Moyce et al., 2015).

Immigration Barriers

Immigration policies have been changed over time to regulate the movement of nurses between countries, mainly in the industrialized countries such as the United States (Masselink, 2014). Whenever there was an acute need for nurses, the United States developed a special visa category to facilitate quick and seamless migration of nurses (Masselink, 2014). Unfortunately, these special visa categories had rigorous stipulations, such as limiting the expatriate nurses to work in certain regions only. This served a counter effect and deterred international nurses from entering the United States to cover the nurse shortages (Masselink, 2014). Immigration processes were also linked to

medical examinations, where only those who were found healthy could be granted employment visas (Masselink, 2014).

English Language Proficiency Tests

Most of the recipient nations for transnational migrations were English-speaking, and expatriate nurses were expected to demonstrate English language proficiency. In some cases English was not the first language for the expatriate nurses. English language proficiency testing was required to prevent unfavorable patient outcomes resulting from miscommunication and language barriers between nurses and patients (Müller, 2016). Furthermore, health care workers were expected to communicate effectively with patients, to understand the patients, and to keep coherent patient records (Rumsey et al., 2016). Top destinations for international nurse migrations included the United States, the United Kingdom, Canada, Australia, New Zealand, and Ireland; and all required prospective healthcare employees to demonstrate competence in English language through passing recommended tests (Rumsey et al., 2016).

According to Rumsey et al. (2016), the recommended testing systems included the International English Language Testing System (IELTS), Occupational English Test (OET), and Test of English as a Foreign Language (TOEFL). Passing these tests could be a challenge for expatriate nurses who were not native English speakers, especially as the stipulated pass marks for nurses were higher than other professions (Timilsina Bhandari et al., 2015; Rumsey et al., 2016). Similarly, Alan and Westwood (2016) pointed out that nurses from the European Union (EU) were not required to take the English language proficiency tests, even though they may not have been from an English speaking

background. This negated the requirement for internationally recruited nurses to be linguistically competent to communicate effectively with patients and other health care professionals. Alan and Westwood (2016) also argued that testing only non-European Union (non-EU) nurses for English language competency was tantamount to institutional discrimination, which could limit highly skilled non-EU nurses from working in the United Kingdom. In addition, this could also lead to professional downward mobility if nurses could not achieve nurse licensure (Alan & Westwood, 2016).

Communication Barriers

Communication was a prominent matter in the literature pertaining to professional integration of expatriate nurses. Both nurses from English speaking and non-English speaking backgrounds struggled with communication in the host countries (Xiao et al., 2014). While the nurses from the non-English speaking backgrounds struggled with language barriers, those from English speaking countries had to contend with learning the slang, jargon, and different words in order to communicate effectively with patients, colleagues, and community members (Timilsina Bhandari et al., 2015).

Some researchers expressed concern that communication barriers among expatriate nurses instilled fear of rejection, evoked feelings of low self-esteem, prevented demonstration of leadership and utilizing their clinical skills, and paralyzed them into silence and keeping a low profile (Moyce et al., 2015; Timilsina Bhandari et al., 2015). Although English language proficiency tests ensured that expatriate nurses could communicate fairly well, some researchers argued that passing tests such as the IELTS did not guarantee that an internationally recruited would be able to understand and be

understood by their patients (Nichols et al., 2015). Intercultural communication required linguistic and pragmatic competence that English language proficiency tests could not provide (Ho & Chiang 2015; Xiao, 2014).

Acculturation Issues

Social scientists recognized that cultural differences contributed to the difficulties expatriate nurse meet when they endeavor to integrate into a new workplace (Xiao et al., 2014). In addition, other researchers agreed that acculturation to the host country nursing system was key to successful professional integration (Willis & Xiao, 2014). Moyce et al. (2015) noted that acculturation was a dichotomous issue for the internationally recruited nurses, who had to acculturate to the host nursing workforce as well as the host country. Moyce et al. (2015) cited differences in the scope of nursing practice as posing unique acculturation challenges for expatriate nurses, for example matters of autonomy and clinical decision-making. Moyce et al. (2015) also observed that nurses from certain backgrounds where the doctor-nurse relationship was marked by power differences found it difficult to adapt to a more egalitarian and dyadic relationship. Nurses coming from predominantly monocultural backgrounds reported experiencing culture shock from having to deal with colleagues and patients from diverse cultural backgrounds (Nichols et al., 2015). In addition, some expatriate nurses newly arrived to Australia cited nurse leaders as having helped with their settling into the new work environments (Nichols et al., 2015; Xiao et al., 2014). Al Yateem et al. (2015) reported similar findings from a study conducted in the United Arab Emirates and Saudi Arabia, in which the expatriate nurses encountered culture shock from looking after Muslim patients. Another problem

of acculturation that was identified by Xiao et al. (2014) was that most of the international nurses were recruited from developing countries such as the Philippines that are grounded in collectivistic worldviews. As a result, these nurses found it difficult to adapt to the individualistic values espoused by the host countries such as Australia. Additionally, the individualistic principles discouraged egalitarianism and propagate racialism and ethnocentrism (Xiao et al., 2014).

Barriers Related to Enculturation

In some instances, the way an individual was socialized socially, culturally, and professionally determined the extent to which they adapted to psychosocial changes such as those resulting from transnational migration (Edgecombe et al., 2013). Researchers from this perspective pointed out that adaptation to a new environment could be influenced by individuals' values and norms, and led to difficulties with forming meaningful relationships with other cultures (Alexis, 2015). According to Willis and Xiao (2014) some expatriate nurses may have been socialized that they came from less developed countries and therefore destined to a low station in life. As a result, this mindset could be carried over into the host country and could impede the effective integration of expatriate nurses. In a similar study, Wolcott et al. (2013) found that some internationally recruited nurses struggled to integrate into the capitalist US healthcare environment, as they were not used to equating direct patient care with budgets. These nurses strongly felt they were only supposed to look after patients, and not count man-hours and patient care costs. Because communication and language were socially and culturally constructed, some expatriate nurses felt uncomfortable with some of the terms

and jargon used by the local nurses and patients, for example when nurses used endearment words to patients (Zhou, 2014).

Barriers Related to Policy

The prevailing global nursing shortage has turned nurses into a much sought after commodity, and new policies have had to be put in place to regulate the processes of transnational migration of nurses and to prevent unethical recruitment of nurses (Adhikari & Melia, 2015). Affluent countries such the US, the United Kingdom, Canada, and Australia have developed state policies that produced a demand for foreign nurses that spanned from recruitment to professional licensure to immigration (Buchan, Twigg, Dussault, Duffield, & Stone, 2015). In a systematic review of the literature examining professional integration of nurses in Canada, Covell et al. (2016) found that some developed nations had made significant financial commitments to facilitate the transition of expatriate nurses into their health care systems. Unfortunately, some of these policies made it difficult for internationally recruited nurses to enter the destination countries (Covell et al., 2016; Prescott & Nichter, 2014).

Perceptions of Deskilling

According to Walani (2015), every professional nurse took pride in their status, and that professionalism was a part of the individual's persona, a part of who and what they are. Ho and Chiang (2015) posited that international nurses developed schemas that were optimistic and confident of the future, which in turn motivated these nurses to migrate to other countries. Similarly, Sherwood and Shaffer (2014) observed that initially expatriate nurses had dreams, which later turned to disillusionment. The migrating nurses

are usually highly skilled and experienced practitioners on the global job market, ready for the highest bidder (Covell et al., 2016). As they arrive in the host country and embark on a process of adaptation and integration into the new society, the expatriate nurses are guided and motivated by the prospects of a bright future.

Studies have shown that expatriate nurses are discriminated against because of their migrant status, and are given entry-level jobs regardless of their previous experience (Moyce et al., 2015). This deskilling or under-utilization adds to the frustration encountered by the internationally recruited nurses during their integration period. Sometimes the professional nurses are relegated to working as healthcare assistants, particularly whilst they are awaiting professional licensure, and may be expected to undergo retraining for basic nursing skills that are way beneath them (Moyce et al., 2015). In other instances, nurses were not allowed to perform basic procedures such as inserting an intravenous cannula without undergoing competencies, and yet the expatriate nurses performed such tasks routinely in their home countries (Bidwell et al., 2014). Xiao et al. (2014) found discrepancies in the acknowledgement of previous experience among expatriate nurses, where Western nurses with the same level of experience as their non-Western counterparts were placed on a higher level; and obviously this led to conflict and disruption to workplace integration. Adhikari and Melia (2015) summarized that expatriate nurses were being mismanaged in the destination countries by ignoring their qualifications, expertise, and experience; and called for policy changes that would see the skills of expatriate nurses better utilized.

Socio-Professional Exclusion

The transferability of nursing qualifications and skills across borders did not necessarily mean that the expatiate nurses were embraced into the host nursing workforce, as shown by results of a metasynthesis conducted across the United Kingdom, Canada, and the United States, Walani (2015). The researcher found that the expatriate nurses experienced socio-professional exclusion from the native nurses, who ignored them and maintained group closure. In addition, the native nurses refused to acknowledge the expatriate nurses' previous nursing experience and skills because of their foreign status (Walani, 2015). The host country nurses tended to stick to their own and did not give the expatriate nurses any help when so required (Timilsina Bhandari et al., 2015). Riden, Jacobs, and Marshall (2014) referred to this exclusion as "professional marginalization" (p.180). Intradisciplinary collaboration and team plating have been found to foster a positive working environment, but expatriate nurses reported difficulties with forming working relationships with the host nurses (Li et al., 2014). This led to feelings of isolation, loneliness, and even depression during their periods of integration (Xiao et al., 2014).

Socio-Cultural Isolation

Humans, like other social creatures liked to have a sense of belonging and maintained ties with their social support systems (Xiao et al., 2014). According to Wheeler et al. (2013) expatriate nurses experienced feelings of social isolation due to dissonance with the new society, felt cut off from their social support system, had language barriers, and felt unaccepted. Furthermore, the expatriate nurses were culturally

isolated because the host society was not familiar or aware of the expatriate nurses' culture (Wheeler et al., 2013). Edgecombe, Jennings, and Bowden (2013) added that a lack of authentic relationships with individuals in the host society heightened the feelings of isolation of the new nurses. The expatriate nurses could not form meaningful social relationships with their colleagues or with the community. The cultural differences formed an invisible wall between the new nurses and their host society (Holmes et al., 2015). Feelings of being an outsider also discouraged the newcomers from reaching out to members of the host community.

Psychosomatic Effects of Stress

The destination countries for the migrating nurses implemented programs and policies to enable smooth recruitment of nurses (Covell et al., 2016). However, some researchers argued that the destination countries neglected the expatriate nurses once they were on board, and left them to struggle with adapting to a new work environment (Connor & Miller, 2014). Expatriate nurses found it very difficult to assimilate into the unfamiliar nursing workforce and experienced high levels of stress, and physical symptoms such as insomnia, depression, loss of weight, altered immune system, diabetes, obesity, and cardiovascular disease ensued (Holmes et al., 2015). This was congruent to the themes identified in a study by Willis and Xiao (2014), in which expatriate nurses experienced intense emotional stress, because they felt alienated and had a loss of sense of belonging. Conversely, support from nursing supervisors and the organization at large enabled the expatriate nurses to develop coping strategies such as focusing on self-appreciation, drawing from their inherent strength, and adjusting and rethinking their

migration schema and expectations; and finally build up resilience (Connor & Miller, 2014; Ho & Chiang, 2015).

Perceived Lack of Support

Nurses integrating into the host country's nursing workforce cited lack of support as a major inhibiting factor to successful professional resocialization (Alexis, 2013; Xiao et al., 2014). Lack of support during the transition period was so crucial that some expatriate nurses were reported to have either moved back to their home countries, or to other organizations in the host country (Geun, Redman, & McCullagh, 2016). Similarly, the lack of organizational support exacerbated the stress that the expatriate nurses were experiencing, and their intent to stay (Gao, Tilse, Wilson, Tuckett, & Newcombe, 2015). Organizational support in the form of comprehensive orientation or acculturation programs, and supervisor support related to mentoring, preceptoring, and accompaniment however, alleviated the integrating nurses' distress and frustrations (Ohr et al., 2014; Pitman et al., 2014). In agreement, Itzhaki, Ea, Ehrenfeld, and Fitzpatrick (2013) mentioned that nurse managers were responsible for developing unit specific educational programs to ensure successful adjustment of the expatriate nurses, which led to job satisfaction and a healthy work environment.

Impact of Nurse Migration on Donor Countries

The migration of nurses did not only impact on the individual nurses, but also affected the donor countries due to the gaps left by these healthcare professionals. This draining of skilled healthcare workers (brain drain) from developing countries to the industrialized countries had a negative impact on the healthcare system of the donor

countries (Marcus et al., 2014; Prescott & Nichter, 2014). One of the major push factors for nurse migration was poor working conditions in the donor countries, and the healthcare systems of some these countries were reported to be on the verge of collapse due the continued recruitment of nurses (Delucas, 2014). Similarly, Backlock, Ward, Heneghan, and Thompson (2014) noted that nurse migration was not solving the shortage of nurses, but rather worsened the global crisis of nurses by maldistributing nurses from poor to rich countries. The affluent countries had an upper hand in the competition for nurses, for example the US, whose nursing workforce was the largest in the world, recruited about 80% of its international nurses from the poor countries (Prescott & Nichter, 2014). In contrast, Li et al. (2014) pointed out that the economic situation of donor countries was improved from the financial remittances from the overseas nurses. In response to the globalization of nursing some donor countries were revising and changing their nursing education curriculums to align them with the nurse education expectations of the recipient countries (Ortiga, 2014).

Impact of Nurse Migration on Recipient Countries

The affluent recipient countries developed policies to attract nurses from international sources, but the question was whether they considered the possible effects of having a diverse healthcare workforce manning their hospitals and looking after their people (Li et al., 2014). Nurse migration has had financial implications on the donor countries because some initiated and implemented programs dedicated to the recruitment, training, and retention of expatriate nurses (Covell et al., 2016). Secondly, the healthcare organization demographics have changed and become more multicultural and

incorporated the practices and worldviews of the new nurses, and the organizational culture and structure had to be revised to align with the new organizational landscape (Santy-Tomlinson, 2015). Thirdly, Li et al. (2014) contended that patient safety was at stake because of language difficulties, different levels of education, and the hampered teamwork stemming from cultural diversity. Finally, the work climate in the host countries was highly strung emotionally as the expatriate nurses adjusted to the new life and simultaneously coped with the "psychological, economic, and social stressors" (Sherwood & Shaffer, 2014, p.50).

Literature Review Related to Nurse Leadership Styles and Behaviors

Multicultural work environments have evoked the need to understand how leaders can best lead these groups of followers while assuring high productivity and organizational success (Washington, 2014). A variety of leadership styles were implicitly and explicitly associated with the work environment, staff motivation, changing workforce demographics, workplace diversity, workplace stress, change, and with concepts and contexts related to integration of individuals. These styles included cross-cultural leadership (Aritz & Walker, 2014), transformational leadership (Guay & Choi, 2015; Lehmann-Willenbrock et al., 2015), transactional leadership, laissez-faire leadership, servant leadership (Chiniara & Bentein, 2015), authentic leadership (Laschinger, Borgogni, Consiglio, & Read, 2015), ethical leadership (Chen & Hou, 2016), leader-member exchange (Luo, Wang, Marnburg, & Øgaard, 2016), empowering leadership (Cheong, Spain, Yammarino, & Yun, 2016), and the dark triad (Rauthman & Kolar, 2013).

Cross-Cultural Leadership

Leaders in culturally diverse countries faced unique challenges such as dynamic and complex situations, dealing with followers with different work ethics, and equally diverse values and norms; and yet these cross-cultural leaders were expected to motivate their followers to achieve organizational goals (Jönsson, Muhonen, Denti, & Chen, 2015). Although there was a dearth of research on cross-cultural leadership, researchers in this field focused mostly on the similarities and differences of leadership attributes across cultures and the influence of culture on leadership perceptions (Lisak & Erez, 2015). Aritz and Walker (2014) identified the need to determine the best techniques and behaviors that leaders could use to maximize the effectiveness of teams in cross-cultural milieus. Aritz and Walker (2014) also suggested studying cross-cultural leadership from a social constructionist perspective, where expected leadership behaviors were co-constructed through the interactions between the leader and the led. This approach was connected to professional integration of expatriate nurses because it aligned with the constructivist stance guiding the current study, in which the new nurses also constructed and made meaning of the world around them from their interactions with their colleagues, patients, and the work context (see Charmaz, 2014).

Cross-cultural leaders had to be aware that their followers had different values of leadership, and leadership expectations and interpretations based on enculturation and socialization (Aritz & Walker, 2014). For example, a leader exhibiting participatory leadership behaviors could be perceived as weak by some followers, and leader assertion could be construed as aggression from other cultural perspectives (Washington, 2015).

An effective cross-cultural leader assured positive organizational outcomes by developing a fit between themselves and the group through focusing on interpersonal attributes, traits, and characteristics that engendered team cohesion, collaboration, and cooperation (Lisak & Erez, 2015). The more aligned the leader's styles and behaviors were to the followers' values, the more likely they were to succeed in achieving culturally adapted leadership (Mustafa & Lines, 2013).

Socio-professional exclusion was mentioned as one of the factors contributing to expatriate nurses' negative experiences in the host country. Aritz and Walker (2014) found in their study that adopting cooperative leadership styles enabled cross-cultural leaders to maximize feelings of inclusion among culturally diverse work groups. According to Lisak and Erez (2015), cross- cultural leaders effectively managed culturally diverse work settings by enhancing their cultural intelligence capital, and adopting a global identity (a sense of belonging in the prevailing global community). This resulted in facilitating better communication, fostered understanding of other cultures, and promoted high quality cross-cultural leader-member exchange. Based on the results of their study of the role of values on adapted cultural leadership styles, Mustafa and Lines (2013) proposed that to ensure its success and international transferability, the cross-cultural leadership paradigm needed to adopt both the realist and relativist stances. The realist standpoint posited that all leadership behaviors and processes should be similar among leaders despite the cultural differences, because they all practiced leadership in culturally diverse settings; and the relativist approach contended that cross-

cultural leadership might not be transferable to other regions, because the leadership outcomes were influenced by cultural differences (Mustafa & Lines, 2013).

Transformational Leadership

Transformational leadership (TFL) motivated followers to achieve higher order needs such as self-esteem and self-actualization goals, and to perform optimally by transforming the followers' values, beliefs, and attitudes (Ryan & Tipu, 2013). According to Nahavandi (2015) transformational leaders used charisma and inspiration to influence followers to undertake change on a grand scale. Additionally, transformational leaders motivated their subordinates to "… transcend self-interests for the sake of the organization" (Lehmann-Willenbrock et al., 2015, p.1018). This transformation was facilitated with the use of tools that were the four behaviors encompassed by TFL, inspirational motivation, idealized influence, individualized consideration, and intellectual stimulation (To, Tse, & Ashkanasy, 2015). Transformational leaders used these four dimensions of TFL to build a sense of community that was used to nurture relationships, foster shared values, transmit trust, and inspire and challenge the followers to perform above their own expectations (Guay & Choi, 2015).

Inspirational motivation. When a charismatic leader inspired followers a strong bond was formed between them, and this in turn stimulated loyalty and trust (Nahavandi, 2015). This type of motivation consolidated team belongingness, and fostered a sense of team identity, collaboration, and concern for others (To, et al., 2015). Transactional leadership, a part of the full range of leadership theory, had been criticized for discouraging employee innovativeness, but inspirational motivation complemented that

by encouraging creativity among followers (Ryan & Tipu, 2015).

Idealized influence. This concept pertained to what To et al. (2015) referred to as influencing followers to rise to higher levels of achievement. These followers were motivated to such an extent that they surmounted challenges and reached unprecedented levels of achievement. Leaders enacting idealized influence motivated followers to maximize their performance by showing concern for the followers, attending to the followers' needs, and participating actively in the occurring change (Ryan & Tipu, 2013).

Intellectual stimulation. In this situation, the transformational leader stimulated the followers' intellect to enable them to solve problems creatively, and to engender personal growth (To et al., 2015). Nahavandi (2015) also observed that employees thrived whenever they were given such autonomy and challenged intellectually, and the transformational leader ensured this outcome by encouraging followers to look at problems in new ways, to challenge the status quo, and to participate in stimulating and even controversial discussions.

Individualized consideration. Transformational leadership situations involved both the interaction between the leader and the team, as well as between the leader and each individual follower (To et al., 2015). With individualized consideration, the focus was on the development of a leader-member dyad, where each received personal attention from the leader; and encouragement and motivation ensued, and culminated in enhanced performance and effectiveness on the follower's part (Luo et al., 2016).

Although transformational leadership has been cited as the epitome of employee motivation and positive organizational outcomes, other scholars contended that

transformational leadership produced followers that were dependent on the leader (Cheong et al., 2016). Studies have shown that expatriate nurses used social capital as a resource for coping with stress (Li et al., 2014). In a study to examine how transformational leadership style impacted on the social capital and networking behaviors of followers, Anderson and Sun (2015) found that followers of transformational leaders derived the social capital from the leaders. Consequently, these followers could not develop social capital networks of their own.

Transactional Leadership

The basic premise of transactional leadership style was that the followers accepted rewards and recognition in exchange for higher productivity and successful completion of assignments (Ali, Jangga, Ismail, Kamal, & Ali, 2015). Transactional leadership was composed of the sub-constructs contingent rewards, in which roles were clarified by the leader and the followers accepted them and agreed that material and psychological rewards were contingent upon goal achievement, and management by exception (Clarke, 2013). Management by exception (MBE) was in turn divided into two dimensions, active and passive; and the leader in active MBE monitored followers' actions and took action before serious consequences occurred, whereas in the passive MBE the leader only reacted after a problem had occurred (Clarke, 2013; Luo et al., 2016). In contrast to transformational leadership that sought to promote change, transactional leadership maintained stability by focusing on and encouraging good performance (Luo et al., 2016). Researchers examining employee outcomes in relation to transactional leadership found that employee commitment and job satisfaction lasted for a

short period, and also impeded staff creativity because the leader set the role expectations (Ryan & Tipu, 2013). With regards to the contingent reward system, individualistic cultures were more accepting because the system involved singular recognition of efforts (Nahavandi, 2015).

A meta-analysis conducted by Clarke (2013) to determine if transactional and transformational leadership transmit safety leadership found that the principle of management by exception involved enforcing rules and looking for mistakes, which eventually led to employee dissatisfaction. Other researchers concluded that even though transactional leadership resulted in higher employee performance, it was more effective only for short periods, for example during turn around programs in failing organizations (Arnold et al., 2015). Additionally, the transactional leader needed to switch to a long-term leadership mode such as transformational leadership style.

Laissez-Faire Leadership

Laissez-faire leadership style was referred to as non-leadership because the leader had no sense of responsibility and did not perform any leadership tasks (Ryan & Tipu, 2013). In addition, such leaders did not participate in important organizational matters, were not concerned with productivity, did not use authority, and avoided making decisions. This non-leadership inevitably frustrated the followers because they did not receive direction or reinforcement (Nahavandi, 2015). Similar to management by exception in transactional leadership, the laissez-faire leader only acted whenever there was a need for negative reinforcement (Ryan & Tipu, 2013). In their study of emotion regulation and burnout among employees, vis-à-vis leadership styles, Arnold et al. (2015)

found that leaders exhibiting laissez-faire leadership behaviors were empathetic to their followers because they expended their emotions and energy trying to deal with the negative effects of the destructive atmosphere that resulted from the laissez-faire leadership style.

Servant Leadership

Servant leadership has gained popularity among organizations determined to succeed, and has been cited as a core value most sought after by progressive organizations and organizations with a culturally diverse workforce (Sun, 2013). The primary difference between servant leadership and other forms of leadership was that servant leaders placed the needs of their subordinates before their own, had a sense of altruism, and encouraged the growth and empowerment of the followers (Sun, 2013). In comparison with other desirable leadership styles, the uniqueness of servant leadership lay in its view of the leader as a servant who sought to attend to the needs of the followers (Chiniara & Bentein, 2016). Another distinction was that servant leadership focused on interpersonal acceptance, authenticity, providing direction, and promoting team effectiveness (Song et al., 2015).

Based on the assertion that servant leadership was still in its infancy and required more research to maximize the understanding of servant leadership in relation to certain variables, Hunter et al. (2013) sought to remedy the knowledge gap by testing how servant leadership influenced employee and organizational outcomes. One interesting finding from the study was that followers considered servant leaders their role models and adopted the servitude attributes and used them to assist and support their fellow

followers. This aspect of servant leadership could help to break down the professional exclusion barriers to professional integration reported by expatriate nurses. Song et al. (2015) in turn, added to the servant leadership knowledge base the dimension knowledge sharing, which in turn fostered collaboration and teamwork among employees.

Authentic Leadership

Authentic leaders were described by Laschinger et al. (2015) as possessing hope, confidence, ethics, positivity, enhancing the followers' self awareness, and fostering collective leadership. Unlike transformational leadership that emphasized leader actions leading to change, authentic leadership focused on leader characteristics such as morality; and the authentic leaders understand whom they were, and strove to align who they were with what they did (Hinojosa, McCauley, Randolph-Seng, & Gardner, 2014). Authentic leaders portrayed themselves to others as genuine individuals through (a) relational transparency, where they showed who they truly were, (b) balancing processing, through which different perspectives were taken into cognizance when making decisions, (c) moral and ethical behavior, and (d) self awareness (Hinojosa et al., 2014; Laschinger et al., 2015; Nelson et al., 2014).

Positive outcomes of authentic leadership included enhanced employee psychological well-being, a positive, secure work climate, development of autonomy by the followers, development of collegial relationships between followers, followers adopting the leader's authentic behaviors, and retention of nurses (Nelson et al., 2014). Further, Nelson et al. (2014) found that authentic leaders propagated a healthy work environment that supported fair treatment of people, whose antithesis was discrimination

experienced by expatriate nurses in the host countries. Another connection between authentic leadership and professional integration of nurses was based on the premise that authentic leadership promoted occupational coping self-efficacy, which was an intrapersonal coping resource from which individuals drew to deal with stressful situations (Laschinger et al., 2015).

Ethical Leadership

Organizational trust was essential to engender employee engagement, and leaders engendered that trust among employees by adopting and utilizing ethical leadership behaviors (Engelbrecht, Heine, & Mahembe, 2014). Ethical leaders transmitted ethical behaviors to their followers through role modeling and andragogical learning principles of social learning (Chen & Hou, 2016). An ethical leader was trustworthy to the followers, and evoked perceptions of safety and ultimately job satisfaction and engagement. Followers of ethical leadership cited support, both at the departmental and organizational level, as the motivating factor to trust (Makaroff, Storch, Pauly, & Newton, 2014). Expatriate nurses engaged in the process of integrating into the host nursing work force reported that lack of support as one of the challenges encountered (Xiao et al., 2014; Walani, 2015).

Leader-Member Exchange

Leader-member exchange (LMX) addressed the quality of the relationship between leaders and their followers (Luo et al., 2016). Leaders formed dyadic relationships with each follower, and each relationship was unique in the quality of the exchange (Nahavandi, 2015). In addition, the quality of the leader-member exchange

compartmentalized the followers into either the leader's in-group or out-group. The followers in the in-group enjoyed a mutually beneficial relationship with the leader, and those in the out-group had a poor leader-member exchange relationship (Nahavandi, 2015). Direct superiors such a nurse leaders determined the motivation levels of subordinates through the quality of the LMX.

The quality of the LMX was important among expatriate nurses transitioning into a new work environment because of the reported instances of institutional discrimination and socio-professional exclusion when the nurse leaders formed an in-group with the local nurses. In a study to test the transferability of LMX across different cultures, Lee et al. (2014) found that the quality of the LMX depended on the subordinate's cultural orientations. For example, a follower from a culture with a high power distance (the extent to which a follower could disagree with the leader) formed a low quality LMX with their leader based on their socialization of never questioning authority (Lee et al., 2014). LMX was also connected to professional integration, based on a study by Luo et al. (2016) who found that the followers' self-concept was influenced by the quality of the LMX with the leader. The concept of self-concept was related to deskilling as experienced by expatriate nurses.

Empowering Leadership

Empowering leadership, like the other value-based and supportive leadership styles, emerged in response to changes in the work environment, the need to maximize organizational performance due to the constantly changing external environment, and responding to employees' needs (Cheong et al., 2016). According to Amundsen and

Martinsen (2014a) an empowering leader was one who shared power with the followers, supported them, and encouraged autonomy. Authority was delegated to the lowest levels in the organization, and employees took part in making competent organizational decisions (Amundsen & Martinsen, 2014b). The delegating of authority to the lower levels was made possible by the flattening of organizational hierarchies in an effort to compete, improve quality and efficiency; and to survive the changing organizational landscape (Biemann, Kearney, & Marggraf, 2015).

The connection between professional integration and empowering leadership was based on one of its outcomes, psychological empowerment, which was a form of psychological capital (Biemann et al., 2015). In consequence, expatriate nurses drew from this psychological capital to cope with stress and feelings of alienation in the host society. Empowering leadership had other positive outcomes such as employee motivation, higher performance, enhanced self-efficacy, job satisfaction, self-leadership, and psychological empowerment (Cheong et al., 2016). Conversely, other researchers criticized empowering leadership, and argued that negative outcomes such as subordinates misconstruing the power sharing as permissiveness, an increase in job-related tension when subordinates could not handle the authority; were associated with empowering leadership (Amundsen & Martinsen, 2014b). Cheong et al. (2016) added that over-confident subordinates could make decisions detrimental to the organization's success and livelihood.

Dark Triad

Although most research has focused on positive forms of leadership styles, some research studies investigated the impact of negative leadership styles and traits on organizational outcomes. Dark personality traits have been identified in some of the individuals who changed the course of history (Nahavandi, 2015). The negative traits exhibited by destructive leaders included callousness, manipulation, ruthlessness, self-centeredness, aggression, and a sense of grandiosity (Volmer, Koch, & Göritz, 2016). The dark triad, a combination of three malevolent traits namely narcissism, Machiavellianism, and psychopathy, has attracted the attention of leadership and organizational psychology scholars (Jones & Neria, 2015). From a behaviorist perspective, the dark triad cluster of personality traits were considered as personality disorders, but the subclinical forms of narcissism and psychopathy were considered normal (Nahavandi, 2015; Rauthman & Kolar, 2013).

Machiavellian leadership style. Leaders with Machiavellian personality traits were cunning, cold and aloof, had low concern for others, and had no scruples with manipulating others to benefit themselves (Nahavandi, 2015).

Subclinical psychopathic leadership style. Psychopathic leaders exhibited impulsivity, were thrill seeking, had no self-control, and had difficulty regulating their affect (Volmer et al., 2016).

Subclinical narcissistic leadership style. Narcissists were characterized by aggrandizement, a high need for admiration, arrogance, exhibitionism, a sense of superiority, and to needed to have their ego reinforced frequently (Nahavandi, 2015;

Volmer et al., 2016).

Attractive side of the dark triad. Leaders exhibiting dark triad personalities would be expected to only engender a toxic and negative work atmosphere, but in a study about the dark triad and employee wellbeing, Volmer et al. (2016) found that subordinates of narcissistic leaders reported higher levels of wellbeing and career progression. The narcissistic trait of desire for admiration contributed to the leaders' efforts at facilitating the employees' promotion and career success. Lack of career success and being passed for promotion were some of the challenges reported by expatriate nurses in the destination countries (see Walani, 2015). In leadership situations and organizational contexts, individuals possessing the dark personality traits were more desirable as they had no qualms with handling and controlling people (Nahavandi, 2015; Volmer et al., 2016).

Follower Perspective

The views and perceptions of followers towards a leader's styles and behaviors contributed to the understanding of art of leadership and the development of leadership (Junker & van Dick, 2014). The followers were the consumers of leadership behaviors and should have had a say in the development and practice of leadership. According to Nichols and Cottrell (2014), followers desired to see certain traits in their leaders that they believed would produce the leadership style and behaviors congruent with their expectations. Additionally, Nichols and Cottrell (2014) found that any discrepancy between the followers' expectations of leadership traits and behaviors resulted in negative organizational outcomes due to the perceptions of disillusionment and

associated job dissatisfaction and disengagement. To answer the research question of how leadership was related to self-concept, Luo et al. (2016) established that followers brought their self-concept to the organization and used it to understand themselves and the interactions with others. According to Luo et al. (2016), self-concept also related to an individual's self worth and evoked in followers different behaviors, attitudes, and perception of leadership. The self-concept possessed by a follower influenced the behavioral traits they expected their leaders to exhibit (Luo et al., 2016).

Impact of Leadership Styles on Individual Nurses

Effective leadership styles and behaviors were essential for creating an ideal context in which the expatriate nurses integrated with as little disharmony as possible (Washington, 2015). Negotiating the unfamiliar terrain of a new work environment posed enough challenges for the expatriate nurses without the additional challenge of destructive leadership behaviors. Saleem (2015) declared that the quality of leadership impacted the followers' attitudes towards their jobs. A discussion on how leadership styles influenced individual nurses focused on job satisfaction, employee well-being, work-related stress, staff engagement, intent to stay, and organizational citizenship behavior.

Job satisfaction. There was a positive correlation between positive leadership styles and job satisfaction (Saleem, 2015). In addition, nursing environments were wrought with situations that were emotionally laden. Managers and leaders in health care organizations could identify and apply interventions to alleviate negative effects in situations such as increased workloads, perceived decision latitude (autonomy related to

decision making and exercising one's professionalism and skills); and social capital (Van Bogaert, Kowalski, Weeks, Van Heusden, & Clarke, 2013). This was important because expatriate nurses cited a lack of opportunities to make decisions, deskilling, and lack of support systems to alleviate the alienation and loneliness.

Junker and van Dick (2014) posited that leaders unconsciously impacted employee job satisfaction due to implicit leadership theory that biased the way leaders rated their followers' performance and rated their impressions of followership; rather than the observed behavior. Implicit leadership theories pertained to the subjective rating of followers in relation to implicit benchmarks (Junker & van Dick, 2014). Communication problems also compromised the perceptions of job satisfaction among employees, because the workforce was heterogeneous, and communication barriers impeded their performance potential (Aritz & Walker, 2014).

Employee well-being. Research studies showed that the quality of the leader-member exchange dyad and other social relationships at work influenced employees' well-being (Leiter et al., 2015). Meaningful social relationships did not remove the stressful demands imposed upon employees, but having solid social and psychological capital in the workplace buffered the effects of stress and challenges and galvanized the employees to develop healthy ways of handling difficulties (Leiter et al., 2015). Multicultural workplaces had unique challenges such as forming and maintaining harmonious cross-cultural work relationships, assuring civility and tolerance, and maintaining group cohesion (Girdauskiene & Eyvazzade, 2015). Leaders therefore were required to foster an ideal work environment that promoted civility and tolerance among

the heterogeneous employees. For example organizations were advised to implement programs that supported workplace diversity (Girdauskiene & Eyvazzade, 2015). To corroborate the importance of trustful interpersonal relationships due to the prevailing complexity in organizations, Santos et al. (2015) suggested that leaders should be trained in functional leadership to maximize team effectiveness. The functional leadership approach was team-centric and focused on the relationship of the leader with the team, not the dyadic leader-member interaction (Santos, et al., 2015).

According to Lornudd et al. (2015), the relationship between leadership styles, behaviors, and employee wellbeing was mediated by factors such as the way employees perceived their work-life balance, meaningfulness of work, clarity of their expected roles, autonomy, opportunities for innovativeness; and efficient team function. When these mediating factors were combined with an employee-oriented leadership style like transformational or authentic leadership, employees reported improved health, less stress, and an enhanced ability to cope with stress (Lornudd et al., 2015).

Workplace stress. Ineffective leadership styles were found to predispose to unhealthy psychological work environments that could lead to stress and associated physical diseases such as ischemic heart disease among employees (Lornudd et al., 2015). Conversely, three-dimensional leadership styles (focusing on productivity, employees, and change) such as the two components of the full range of leadership model, transformational and transactional leadership, created a work environment that promoted the employees' health (Lornudd et al., 2015). Baysak and Yener (2015) determined that leadership styles and stress, absenteeism, reduced productivity; and

burnout resulted in considerable costs to the organization.

Other researchers adopted a different perspective and described strategies implemented by some progressive healthcare organizations to combat work-related stress. These strategies included actions such as ensuring uninterrupted meal breaks, providing relaxation rooms for emotionally intense units such as intensive care; enhancing the physician-nurse dyadic relationship; and creating an employee wellness program (Sanders, Krugman, & Schloffman, 2013).

Intent to stay. Blake et al. (2013) investigated the relationship between leadership and communication and collaboration between intensive care nurses and their leaders, and found that nurses left organizations to find better leaders. Additionally, the relationship between the variables investigated was crucial because of the stressful context of the ICU that translated to other emotionally laden nursing situations (Blake et al., 2013). Conversely, improving the leadership styles and behavior maximized the nurses' intent to stay. Job satisfaction was of particular importance to expatriate nurses, and organizations and leaders needed to provide a safe workplace, effective orientation, and other dimensions of a positive work environment to retain them (Pittman et al., 2014). In agreement, Itzhaki et al. (2013) suggested the provision of adequate mentoring for expatriate nurses and education to maximize job satisfaction and promote the intent to stay.

Tyczkowski et al. (2015) advised leaders to enhance their emotional intelligence skills to be able to regulate their own emotions to manage their followers' emotions and ultimately foster a healthy work environment and concomitant staff retention.

Emotionally intelligent leaders also stimulated perceptions of job satisfaction, trust in the leader; and psychological safety in the followers through the transformational leadership dimensions of individualized consideration, inspirational motivation, and idealized influence (Tyczkowski et al., 2015).

Staff engagement. Employees were engaged when they experienced positive feelings and a sense of fulfillment towards their work; and felt energized and motivated to engage in work (Gillet et al., 2013). Staff engagement was an action undertaken by leaders to ensure followers transitioned smoothly into workplace, had clear roles, and were motivated and enabled to function and perform to their utmost (Laschinger et al., 2015). The concept of staff engagement has been investigated in relation to leadership styles, and has continued to attract the attention of leadership scholars (Blake et al., 2013).

According to Laschinger et al. (2015), empowering leadership styles such as authentic leadership style stimulated staff engagement. Empowering leadership styles provided a supportive workplace, opportunities for autonomy and professional growth, and congruence with the followers' expectations (Laschinger et al., 2015). Other researchers also confirmed that ethical leadership supported staff engagement because the leader-member interaction involved trust, transparency, perceptions of fairness and justice; and engendered psychological and physical health (Chen & Hou, 2016).

Ohr et al. (2014) provided the connection between staff engagement and professional integration of internationally recruited nurses in their study. The study findings led to recommendations for organizations to provide systems and processes that

ensured the new nurses were supported throughout. In addition Ohr et al. (2014) called for strong leadership to manage the complexities associated with cultural diversity. On a parallel note, McCabe and Sambrook (2013) pointed out that building staff engagement was an effective method of managing human resources, through which staff shortages were alleviated by maximizing staff engagement and personal commitment.

Organizational citizenship behavior. Leadership behaviors not only influenced the way their followers worked, but also the way they behaved in the organization (Guay & Choi, 2015). Organizational citizenship behaviors referred to enhanced task performance by employees who perceived job satisfaction and a heightened sense of belonging to the organization; and went the extra mile without expecting any extra remuneration (Guay & Choi, 2015). Employees engaged in organizational citizenship behavior (OCB) when they performed beyond their role expectations and acted in different ways to benefit themselves and the organization. The employee actions included showing initiative, collaborating with colleagues, and participating in change initiatives, (Guay & Choi, 2015). Value-based and people-centered leadership styles such as servant leadership promoted organizational citizenship behaviors by fostering followers' growth through satisfying their needs and supporting them (Chiniara & Bentein, 2016). Positive and supportive work environments such as those provided by transformational leaders were positively associated with organizational citizenship behaviors, both for the individual and the organization's benefit (Guay & Choi, 2015).

Impact of Leadership Styles on Organizational Outcomes

The quality of an organization's leadership behaviors determined its survival in the competitive global market (Allen, Smith, & Da Silva, 2013). Organizations were constantly changing in many parts of the world as the workplace was marked by cultural diversity (Girdauskiene & Eyvazzade, 2015). Therefore managing a diverse workplace was a key leadership competency. When leaders created a work atmosphere that supported diversity, used positive leadership styles that fostered job satisfaction and employee engagement, there was evidence that the employees developed organizational commitment and remained with the organization (Guay & Choi, 2015; Pitman et al., 2014). Samad et al. (2015) defined organizational commitment as a psychological link between an employee and the employer that determined the employee's intent to leave. The extent of the organizational commitment in turn determined the organization's success.

Organizations did not only rely on employee-centered leadership styles to ensure employee job satisfaction and well-being and survival against competitors; but also expected leaders to use communication to leverage team effectiveness, improve team performance, and stimulate creativity among employees (Boies, Fiset, & Gill, 2015). Team effectiveness was key to organizational success because of the heterogeneous workforces in most organizations. Huettermann, Doering, and Boerner (2014) supported the premise that leaders enhanced team playing by proposing that leaders promoted the development of collective team identity and team oriented efforts. In a study to investigate the transformational and transactional leadership behaviors of both expatriate

and local leaders in the United Arab Emirates, Bealer and Bhanugopan (2014) found that there was a general lack of understanding of cross-cultural leadership. Furthermore, there was a chasm or power distance between leaders and followers; and a number of organizations did not have strategies of using leadership to get the best out of the employees (Bealer & Bhanugopan, 2014). Other study findings were that leaders in the UAE had less transformational leadership skills than their peers in other countries, and some were found to use the laissez-faire leadership style. The findings by Bealer and Bhanugopan (2014) indicated that the leadership styles in the UAE predisposed the organizations to unfavorable outcomes. This hypothesis would need further testing as Bealer and Bhanugopan (2015) admitted that very little leadership research had been conducted in the UAE. Similarly, negative leadership styles have been found to cost the organizations in terms of staff absenteeism, staff treatment costs, and sick leave (Baysak & Yener, 2015).

Impact of Leadership Styles on Patient Outcomes

The mission of health care organizations was to provide health care services to their clients, and the responsibility of creating a healthy and safe healthcare environment lay with the leadership (Van Bogaert et al., 2013). The environment created by the leader affected the followers in different ways; and in healthcare organizations, the leader's behaviors ultimately affected patient outcomes (Makaroff et al., 2014). Gillet et al. (2013) concurred that it was important for nurses' quality of work life to be improved and enhanced to ensure psychological and physical health, and to motivate the nurses enough to promote organizational citizenship behavior.

Supportive leadership styles such as authentic leadership increased emotional well-being and reduced burnout, and this led to an optimal work environment in which nurses felt empowered to practice their patient care skills (Laschinger et al., 2015). Conversely, destructive and ineffective leadership styles that included the dark triad and laissez-faire were associated with poor outcomes, and nurses felt frustrated and confused, and transmitted the frustration to the patients, who had entrusted their lives in the hands of a demotivated nursing workforce (Baysak & Yener, 2015; Bogaert et al., 2013). Most of the research studies did not include patient outcomes in the discussion section or the implications for practice section. It was left to the reader to assume the possibility of cascading effects from the leadership style down to the patient.

Research Design and Methods

In the following section I gave a brief background to justify the research design and methods selected for this study, and I also explained why qualitative grounded theory method was suitable for this study.

Qualitative Research Design and Methods

Qualitative research has been cited as gaining popularity in nursing research, and Rosenthal (2016) observed that qualitative research studies were appearing more frequently in research journals. According to Foley and Timonen (2015), qualitative research methods enabled the generation of rich descriptions of phenomena in a real world context; as well as the development of theoretical understanding of those phenomena. In addition, qualitative research was found suitable when there was poor understanding of phenomena, to consolidate extant theories that had a perceived

weakness; and when there was not enough information on the phenomena of interest to develop a quantitative measurement tool (Foley & Timonen, 2015).

The key characteristics of qualitative research include (a) the use of the participants' naturalistic environment, (b) emphasis on the context of the phenomena under study, (c) triangulation of data sources such as interviews, observations, and document review, (d) an inductive method of data generation with the researcher as the primary data collection instrument, (e) an interpretive inquiry that includes reflexivity, and (f) a subjective epistemology focusing on the participants' views (Patton, 2015). The main qualitative strategies of inquiry include phenomenology, ethnography, narrative inquiry, case studies, and grounded theory (Creswell, 2013).

Wolgemuth et al. (2015) noted that some qualitative research scholars such as Crotty (1998) and Lincoln and Guba (2007) portrayed qualitative research as paradigm-driven, in which the research study was framed by the theory. Wolgemuth et al. (2015) argued that the paradigm-driven approach limited the emergent and flexible nature of qualitative research, and could stifle the generation of rich and deep data when using interviews as a data collection tool.

Grounded Theory

Unlike in other research approaches where theory is used explicitly as a vehicle to guide the study, grounded theory works inductively from the emerging data up to generation of a theory (Sansfaçon, Brown, Graham, & Michaud, 2014). The grounded theory school of thought developed in the 1960s from efforts by sociologists Barney Glaser and Anselm Strauss to show that qualitative research approaches could be used

systematically to produce studies significantly at par with statistically generated quantitative research (Glaser & Strauss, 1967). The grounded theory research paradigm emerged in response to the notion that social scientists were preoccupied with testing and verifying theories, and neglected generation of theory (Ward, Hoare, & Gott, 2015). Additionally, grounded theory was found to elevate the role of the researched to an equal status with the researcher, and the research findings were grounded in the participants' verbatim account of their experiences (Charmaz, 2014; Ward et al., 2015).

The fusion of Glaser's positivist standpoint and Strauss's pragmatist philosophical background assured a credible and sound philosophical base for grounded theory (Ward et al., 2015). Glaser contributed most of the components of grounded theory that included codifying methods and generating middle range theories (Charmaz, 2014). Strauss later became dissatisfied with the objectivist worldview of grounded theory at that point, and proposed that the philosophical perspective of symbolic interactionism should inform grounded theory (Ward et al., 2015). The justification was that symbolic interactionism would encompass individuals making meaning of their surroundings. Strauss then left Glaser to work with the nurse scientist Corbin to add an interpretivist aspect to grounded theory (Ward et al., 2015). Interpretivism was based on the premise that humans did not respond mechanically to stimuli, but deliberately sought to interpret their environment and interactions with others (Higginson & Lauridsen, 2014; Ward et al., 2015). Eventually another approach, constructivist grounded theory emerged, whose proponents argued that researchers formed a partnership with the research participants and created the data together, and could therefore not adopt an etic approach to the study (Conlon,

Carney, Timonen, & Scharf, 2015). Despite the divergent nature of grounded theory approach, the characteristics of constant comparative analysis, theoretical sampling, theoretical coding, theoretical saturation, and theoretical sensitivity distinguished grounded theory from other qualitative research approaches (Charmaz, 2014, Corbin & Strauss, 2015; Maz, 2014).

Grounded Theory Research in Nursing

Grounded theory research has become the most popular approach among nurses (Handberg et al., 2015). Grounded theory has been found to be attractive to nurse researchers because of its applicability to social and psychological processes related to health and illness (Maz, 2014). In addition, the emergent theory could be used to guide evidence based nursing practice. Even though grounded theory has been cited as the most used qualitative research approach in nursing, challenges have arisen with theoretical sampling with hard to reach populations such as those with conditions associated with stigma for example HIV/AIDS (Foley & Timonen, 2015). Similarly, gatekeepers such as healthcare providers for patients on palliative care have restricted access to the research participants when the researchers wished to obtain clarification from participants, or to follow up on a lead (Foley & Timonen, 2015).

The different grounded theory approaches have been found to be confusing for researchers and some researchers have ended up combining aspects from different approaches that were philosophically different (Howard-Payne, 2016). According to Howard-Payne (2016) the Straussian approach to grounded theory was ideal for studying complex topics such as HIV/AIDS, based on the Straussian underpinning ontology of

pragmatic relativism. Conversely, Ward et al. (2015) challenged objectivist grounded theory in generating evidence for nursing practice, and advocated for constructivist grounded theory; and argued that nurses could not separate the patient's body from its mental state, environment, beliefs, life experiences, or social relationships.

Summary and Conclusions

Transnational migration of nurses has become one of the major themes among health researchers and other social scientists (Neiterman & Bourgeault, 2015b). Current research has focused mostly on the factors that motivated nurses to leave their countries (push factors), as well as pull factors, that is, reasons why nurses chose to go and work in certain countries (Moyce et al., 2015). Other studies have addressed the experiences that expatriate nurses had in the destination countries (Xiao et al., 2015) and the impact nurse migration had on the donor and recipient countries (Prescott & Nichter, 2014). Current research calls for a more in-depth evaluation of the effectiveness of the policies and programs developed by the recipient countries to facilitate the integration of internationally recruited nurses (Covell et al., 2016). To achieve healthy professional integration of expatriate nurses, it was essential to explore the experiences of expatriate nurses in destination countries within the context of the factor most responsible for determining the work atmosphere: leadership. There was little evidence in the extant literature that described the role of nurse leaders in the professional integration of internationally recruited nurses when they arrived in the destination countries.

Chapter 2 reviewed the literature on the experiences of expatriate nurses in the destination countries, including interpersonal relationships, logistic, and regulatory

matters. Discrepancies in the definition of professional integration led to the inclusion in the discussion of nurses' professional integration, rehabilitation of individuals into professional jobs, and assimilation of immigrants into new cultures. I also described different leadership styles and how they affected organizational and employee outcomes.

The gaps in the literature identified in chapter 2 were used to inform the purpose of the current study, to formulate the research questions outlined in Chapter 1, and the selection of the research methodology described in Chapter 3.

Chapter 3: Research Method

There has been an increased interest in the transnational migration of nurses and their experiences during the period of integration into the host country (Prescott & Nichter, 2014), but there is inadequate research on the phenomenon that links the experiences of migrating nurses and leadership influence (Xiao et al., 2014). The purpose of this study was to develop a theory that would help to explain the interface between nurse leadership styles and behaviors and the process of professional integration using the constructivist grounded theory approach. The units of analysis were internationally educated nurses who came to the United Arab Emirates during the preceding 12 months as expatriate nurses. In this chapter, I discuss the research design and rationale, my role as the role of the researcher, the participant selection logic, and methods of data collection. The chapter concludes with a comprehensive overview of the planned data analysis procedure including coding methods, methods of ensuring trustworthiness, and ethical considerations.

Research Paradigm

The choice of a research paradigm and design depends of what the inquirer seeks to achieve, discover, or explore in the study (Maxwell, 2013; Patton, 2015). The qualitative research paradigm guided the current study. Qualitative research enables participants to be studied in their naturalistic environment, and situates the researcher in the world of the researched in which he or she attempts to make meaning of or interpret the focus of the study in alignment with the research participants (Denzin & Lincoln, 2007). Corbin and Strauss (2015) observed that qualitative researchers are able to derive

deeper insights and understanding of the phenomenon of interest when they immerse themselves in the naturalistic environment of the participants.

Qualitative researchers view the world from a process perspective in which they focus on people and their connection to their surroundings and the nature of their relationships (Maxwell, 2013). This paradigm was ideal for exploring expatriate nurses' professional integration. Leadership was described as a social, contextual, and relational phenomenon (Lehmann-Willenbrock et al., 2015). The qualitative paradigm grounded the exploration of this relational aspect of the nurse leaders and expatriate nurses through the constructivist grounded theory approach. Lehmann-Willenbrock et al. (2015) posited that leadership should be examined at the level of actual events, and the focus should be on the leader-member dynamics, particularly their behaviors.

Research Design and Rationale

The constructivist grounded theory study facilitated the development of a theory that related the nurse leaders' styles and behaviors to the professional integration process of expatriate nurses, and was guided by the following research questions:

RQ 1: What are the lived experiences of expatriate nurses in a new work environment?

RQ 2: How would you describe the ideal multicultural work environment that would promote the professional integration of expatriate nurses?

RQ 3: What leadership qualities would enhance the integration of expatriate nurses?

RQ 4: What do you perceive as the key roles of a nurse leader in the professional integration of expatriate nurses?

RQ 5: What are the general experiences of expatriate nurses as they integrate into the destination healthcare organization?

RQ 6: What specific interactions with nurse leaders impacted on the expatriate nurses' integration process?

RQ 7: To what extent did the organizational cultural and structural factors influence the expatriate nurses' integration process?

Central Concepts of the Study

The central concepts/phenomena in the study were the professional integration process of expatriate nurses in relation to the influence of nurse leadership styles and behaviors on the process. Professional integration is defined differently depending on the context, but in this study professional integration was defined as a process in which expatriate nurses merge their roles, functions, professional identities, and expertise acquired from their home country with those of the host country (Tsang, 2014) and become members of a particular work group (Covell et al., 2016). Even though professional integration is influenced by several factors, in the UAE and other GCC countries, the Muslim culture was anticipated to pose significant problems with acculturation, and the expatriate nurses' cultural intelligence levels and intercultural adjustment were anticipated to contribute significantly to the effects of nurse leadership styles. It was surprising that in this study, the participants did not seem to be affected by the Muslim culture of the host country, but by the cultural orientations of their fellow

nurses. Leadership styles are defined as the actions used by nurse leaders to guide and lead their subordinates toward the realization of organizational goals (Saleem, 2015). Symbolic interactionism, one of the theoretical lenses used in the study, emphasizes the way in which individuals make meanings of their interactions with others (Blumer, 1969). The perceptions and interpretations of the expatriate nurses toward the influence of nurse leadership styles were the main focus. The central phenomenon could be impacted by factors such as the experiences of the integrating nurses, intercultural adjustment capabilities, and the degree of cultural intelligence (Malik et al., 2014), language proficiency of the internationally recruited nurses, and the factors motivating nurses to embark on transnational migration.

Grounded Theory Study

The intent of grounded theory is to generate a theory that is grounded in the data generated from the study (Charmaz, 2014). Grounded theory has symbolic interactionism as one its philosophical stances, and premises include meanings of phenomena are derived out of social interaction with others, phenomena are described according to how individuals interpret them, and people react to each other in relation to how they perceive each other (Blumer, 1969; Charmaz, 2014; Zhou, 2014). The influence of leadership styles and behaviors on the integration of expatriate nurses into the host work environment was studied using the grounded theory approach with the intent of generating a theory. The leader-member interaction and the language used between them also supported the use of the grounded theory approach for this study. Murphy, Klotz, and Kreiner (2017) added that grounded theory researchers focus on the context in which

the behaviors and interactions occur, and those experiences can then be translated into explanatory theories.

The objectivist grounded theory proponents portray the researcher as an objective data collection tool, but the constructivist grounded theory school of thought acknowledges that the researcher is an active and contributory member of the researcher and researched dyad (Hoare, Mills, & Francis, 2013). The constructivist grounded theory approached was selected for this study because it enables research participants to make sense of the world around them and their experiences by constructing that world as they interpret the phenomenon under study (Charmaz, 2014; Patton, 2015). In addition, the constructivist grounded theory method emphasizes the interaction between the researcher and the research participants, in that the quality of the interaction determines the quality of the interview and subsequently the quality of the data (Mulugeta, Williamson, Monks, Hack, & Beaver, 2017). This point was also a motivating factor for the decision to adopt the grounded theory approach for this study, because I am also an expatriate nurse who shares a life experience with the research participants. Coming to the research situation without necessarily being tabula rasa and without needing to bracket my previous experiences with the phenomenon under study helped me to minimize researcher bias by practicing reflexivity.

Grounded theory is a systematic but flexible method in which analytical thinking is used through constant comparison to derive themes that are then reconstructed into theoretical concepts through hierarchical aggregation (Mulugeta et al., 2017). In keeping with the grounded theory tradition, I used purposeful sampling in conjunction with quota

sampling (see Robinson, 2014); I collected data through semistructured interviews, document analysis, and memos; and I analyzed the data using the constant comparative methods. I generated codes through initial line-by-line coding, focused and axial coding, and theoretical coding (Charmaz, 2014; Mulugeta et al., 2017). I used theoretical sampling and abductive reasoning to make my emergent categories more robust and meaningful, and my interpretation of the relationships between the core categories culminated in my generating a substantive theory.

Rationale for the Research Tradition

The qualitative grounded theory approach was used because it fulfilled the purpose of the study, which was to inductively generate a theory that would help to explain the human interactions between the nurse leaders and expatriate nurses (Hall, Griffiths, & McKenna, 2013). There are different grounded theory approaches (Glaser & Strauss, 1967; Charmaz, 2014) described by Ralph, Birks, and Chapman (2015) as "methodological dynamism" (p. 1). In this study constructivist grounded theory (Charmaz, 2014) was used to answer the research questions. The grounded theory approach is the preferred research method when little is known about the phenomenon of interest and the inquirer seeks to derive a deeper understanding of the manifestations of that phenomenon (Foley & Timonen, 2015).

According to Charmaz (2014), grounded theory helps researchers to explore their worlds and develop theories that aid in understanding phenomena. In addition, the constructivist grounded theory researcher studies processes and interactions from an emic rather than etic perspective, and constructs theories based on previous experiences with

the phenomenon of interest. Adopting the grounded theory approach enabled me to reduce the researcher-participants power differences as the participants' views and interpretations were given a central place in the generation of data (see Conlon et al., 2015). In addition, the grounded theory approach I used enabled me to collect and analyze data through the constant comparative method, derive codes, and use theoretical sampling to build up the core categories and reach saturation and theory development.

Role of the Researcher

My role included designing the study, identifying gatekeepers through whom I established contact with the research sites, and recruiting and selecting the participants. In line with the grounded theory tradition, I used purposeful and theoretical sampling to recruit participants. In addition to the Walden University institutional review board (IRB) approval, I also sought permission from the regulatory boards in the UAE where I conducted my research, such as the Dubai Health Authority, and from the ethics committees of the participating acute care hospitals. The qualitative researcher is the primary data collection instrument, and I personally collected and analyzed the data (see Maxwell, 2013). I designed the interview guide (Appendix A) that I used to direct my semistructured interviews, and the demographic data survey form (Appendix B) that I used to screen the participants for inclusion criteria. I also obtained written consent from the participants after informing them of the requirements of the study. As a constructivist grounded theory researcher, my role was also to co-construct the data with the research participants (see Charmaz, 2014).

Researcher Bias and Conflicts of Interest

The qualitative researcher spends considerable time with the research participants, and this closeness to the data could lead to bias in a research study (Corbin & Strauss, 2015). Charmaz (2014) stated that researchers in the constructivist paradigm could not be separate from the research situation. This could also introduce researcher bias. This was pertinent in my case because I am an expatriate nurse, and I acknowledged this fact in the research report. I used reflexivity through memo writing to minimize researcher bias and maximize the rigor of the study. Engward and Davis (2015) contended that the research situation is related to the researcher's sociocultural position. Throughout data collection and analysis, I examined my feelings, previous experiences, and thoughts toward the data and wrote memos on my thoughts to minimize researcher bias. Even though Charmaz (2014) argued that the researcher and the researched co-construct the data, I tended to let the research participants take center stage through semistructured interviewing and letting them talk as much as they could to obtain thick and rich data. Because situations involve power relationships between the researcher and the researched (Maxwell, 2013), I selected only participants and hospitals that had no professional association with myself to minimize this risk. This study was not funded, so there were no financial interests associated with the study. There was no conflict of interest because I was not affiliated in any way with the participating hospitals or research participants.

Methodology

Qualitative research is conducted to explore, discover, and understand individuals' experiences and behaviors in relation to life situations, and data are

commonly collected through individual or focus group interviews, observations, and document review within the participants' natural environment (Patton, 2015). The current study followed the plan in which quota purposeful sampling was used and data collection was done through individual interviews, document examination, and a demographic survey.

Participant Selection Logic

Research population. The study population comprised expatriate nurses who came to the UAE within the preceding 12 months; nurses were recruited from countries such as India, the Philippines, South Africa, Jordan, Nigeria, Pakistan, Lebanon, the United Kingdom, and the regions of Eastern Europe and North Africa. The participants were registered nurses working in a nonleadership role as direct reports to the charge nurse, charge midwife, or unit manager in acute care hospitals in the UAE. Purposeful theoretical sampling (Patton, 2015) was used to recruit and select the participants from among individuals who responded to invitation emails sent through the health care institutions' gatekeepers.

Sampling strategy. According to Robinson (2014) determining the target population or universe, sample size, sampling strategy, and identifying ways of contacting and recruiting the research participants enhances the coherence and trustworthiness of a study in terms of transferability. Purposeful quota sampling was used initially, and then theoretical sampling was used until theoretical saturation was reached. Theoretical samples included extant peer reviewed literature and expatriate nurses. With purposeful sampling researchers seek out information-rich participants who can provide

rich and thick data that adds to the theory being developed (Maxwell, 2013; Patton, 2015). Quota sampling (Robinson, 2014) was done to assure that the major and minor donor countries for expatriate nurses were fairly represented in the sample, and most of the participants were from India and the Philippines, with the rest from Africa, the Middle East, and Europe.

Criteria for participant selection. Qualitative grounded theory research is designed to explore individuals' social interactions in relation to a particular phenomenon (Patton, 2015), and such a population should have been exposed to that phenomenon. The participants in the current study shared life history homogeneity as described by Robinson (2014), were in their first year in the UAE following recruitment from their home countries, and this was their first transnational migration experience. To ensure representativeness of the target population, transferability and credibility of the study findings, the sample also had demographic and geographical heterogeneity (Robinson, 2014). At least half of the sample consisted of nurses from India and the Philippines, which are the two major donor countries of expatriate nurses to the UAE; and the rest of the sampling was spread out evenly to cover Europe, Africa, and the Middle East. The justification for the selection criteria was that 80% of the population in the UAE is composed of foreigners, and nurses are part of the international workforce that responded to the global market demands (Bealer & Bhanugopan, 2014; El Amouri & O'Neill, 2014). Because English language proficiency was a recruitment requirement in the United Arab Emirates, there was no language barrier between the research participants

and myself. The minimum nursing experience stipulated by the UAE government is two years, and this was the same selection criterion for my research participants.

Sample size. The target sample was originally planned to consist of about 20 to 30 participants, evenly distributed across the participants' country of origin and the three participating healthcare organizations. This number is typical of grounded theory research and is nomothetic enough to assure credibility of the generated theory, but small enough to ensure each participant's voice is locatable in the study (Creswell, 2013; Robinson, 2014). According to Patton (2015) there are no rules that prescribe the size of the sample in qualitative research, but the number of research participants is determined by the research purpose and the extent to which the researcher ensures research rigor. In this study, the final number of 10 research participants and two reviewed documents were determined by the stage at which theoretical saturation was reached and when the tentative conceptual categories emerged from the data (Foley & Timonen, 2015). In addition, the high number of research questions also helped to derive rich and thick data from which the analytic categories emerged to develop a middle range theory.

Sample characteristics. I selected the sample that covered diverse characteristics such as age, where the range was between 26 and 45 years of age; years of nursing experience, and included nurses with four years experience and those with over 10 years experience; religion, and ethnicity. The sample also included both the male and female genders. According to Mittal and Dorfman (2012), "... culture-specific preferred styles of leadership exist side by side with universally endorsed behaviors" (p. 556).

Procedure for participant recruitment. According to Maxwell (2013) the researcher should seek to negotiate and establish research relationships through gatekeepers. For this study, the chief nursing officers, or other designated officials serving a similar function, of the participating healthcare organization had the ascribed role of gatekeeper. Permission to approach the potential research participants was sought from the chief nursing officers of the acute care hospitals that had expatriate nurses in their employment. 10 hospitals were approached and three agreed to participate in the study. The invitation letters to participate in the research study included my email address and telephone number so that potential participants could contact me. The invitation letter also included a brief description of the study and a sample of the informed consent form.

Some registered midwives showed interest to participate in the study but they were excluded because the study specifically required registered nurses. This was explained to those registered midwives via email and I thanked them for their interest in the study. Demographic survey forms were sent to the potential participants to determine if they met the inclusion criteria. Quota sampling was then done on the purposefully obtained sample to derive an initial sample of research participants. India and the Philippines have the highest number of expatriate nurses in the UAE, therefore a larger number of the research participants were selected from these two countries.

Saturation and sample size. Qualitative research begins with an a priori sample size, but the sample size usually changes due to the flexible nature of the qualitative research approach (Maxwell, 2013). The numbers of units of analysis continue to change until data saturation is reached. In contrast, grounded theory research focuses on

theoretical saturation, rather than data saturation, and theoretical sampling is done to consolidate the developing key categories (Corbin & Strauss, 2015). In grounded theory the sample size depends on the research objective, and a larger sample is selected if the aim of the study is to generate a theory, with a smaller sample used when the researcher seeks to test a theory (Charmaz, 2014). According to Creswell (2013) and Patton (2015) the proposed sample size for this study would have been adequate to address the intent of grounded theory, as well as ensuring trustworthiness of the findings. The planned sample size of 20 participants was not obtained because the research participants took longer to respond, and one of the three participating hospitals withdrew due to commitments elsewhere. The participants were interviewed as they volunteered I recruited them, and I did not wait until I had a certain number of participants. The number of participants was increased due to theoretical sampling, as new data were required to fill out the emerging codes and categories (Bagnasco, Ghirotto, & Sasso, 2014). Follow-up interviews with some of the participants were conducted as part of theoretical sampling. Two documents were reviewed at the research sites and the data were then transcribed and analyzed later. The final sample size of 10 research participants and two documents depended on the stage at which theoretical saturation of the category properties were achieved.

Context of Study

The study was conducted in two acute care hospitals in the larger emirates of Dubai and Abu Dhabi. The UAE is made up of seven emirates, with the other five being relatively smaller than Dubai and Abu Dhabi. The larger emirates are more populous and have a higher number of expatriate nurses due to the higher number of private hospitals

recruiting their nurses predominantly from overseas. The larger emirates were selected for this study because they exemplified the 80% expatriate workers norm of the UAE.

The face-to-face interviews were conducted in a quiet restaurant outside peak times, and the adjoining tables were also booked to maximize privacy of the interview session. The telephone interviews were conducted from my home, where I locked the door and I ensured nobody came to my house during those times in order to minimize any disturbances and possible intrusion into the interview session.

Instrumentation

In qualitative research studies the researcher is the primary data collection instrument and should rely on their eyes and ears as data collection tools (Maxwell, 2013). To assist with data collection through exploring the perceptions of the expatriate nurses on how the nurse leadership styles and behaviors impacted on their integration process, I developed an interview protocol that I used to guide both face-to-face and telephone interviews (see Appendix A). The demographic survey form was used to screen the participants for inclusion and exclusion criteria, and included information such as age, years of nursing experience, and ethnicity, among others (see Appendix B). The interview guide was developed mainly from the research questions and also from literature sources that pertain to transnational migration of nurses, as well as sources related to leadership influence on the work environment. I did not use any protocol for document review, but I used content analysis to examine the documents.

The interview questions were designed to provide direction for the interviews and to permit the following of leads and prompts to develop other questions to derive deeper

data. Aligning the interview guide with the research questions contributed to maximizing trustworthiness of the data from my study. In addition, each participant was asked the same questions during the interviews. For example, I asked the participants what qualities a leader should have in order to promote professional integration of expatriate nurses; and to describe situations in which they felt their leader exhibited positive leadership behaviors.

Even though triangulation is considered a method of ensuring validity, Maxwell (2013) contended that reducing the threats to validity was more infallible. In the current study the interview guide was adhered to, whilst watching out for other validity threats, and I used probing to explore some answers given by participants. Selecting only the participants who met the inclusion criteria ensured content validity in the form of sampling validity (see Frankfort-Nachmias & Nachmias, 2008).

Procedures for Recruitment, Participation, and Data Collection

Participant Recruitment and Participation

Participant recruitment. I selected the private acute care hospitals in the two larger emirates of the UAE because they have the largest concentration of expatriate workers, and because they allowed research studies to be done by anyone who so wished. The government hospitals in the UAE employ larger numbers of the UAE nationals and allow only their own employees to conduct research studies. I sent e-mails to the chief nursing officers of ten private acute care hospitals requesting permission to conduct research in their organizations. The hospitals took longer to respond to my request because most of them did not have ethics committees, and these had to be set up before I

could be granted permission to conduct my research study. Three hospitals agreed to be my research partners. I then set up meetings with each of the individuals designated the responsibility of oversight of research studies, to discuss the research requirements. All three hospitals asked me to first obtain Walden University IRB approval before they could give me their approval. My IRB approval number was 02-23-17-0352193, expiry date February 22, 2018. One participating hospital withdrew from the study due to circumstances beyond their control.

The CNO gave me the e-mail addresses of potential research participants, with their consent and the human resources department's permission, and I then sent them the invitation letter to participate (see Appendix C). The letter included my contact details. The potential participants who expressed interest in participating in the study were sent the demographic survey form. Those who met the inclusion criteria were called to discuss in more detail the study requirements, and the informed consent form was also discussed at this point. The participants were given the option of in-person or telephone interviews and the date and times of the interviews were then set. The telephone interview participants received the informed consent forms by e-mail and I sent back to them a signed copy for their records. The consent form also included the information that they would receive a coffee voucher for AED 50 (US$13) after the interviews.

Participant selection. Seven participants expressed interest to participate in the study, but from the demographic survey forms received through e-mail, three were registered midwives and two had previously worked in other hospitals in the UAE. These did not meet the inclusion criteria and were informed and thanked for showing interest in

the study. Four more potential participants responded to my invitation but later decided not to participate in the study. Two more did not respond to further contact to arrange the interviews. My final number of participants was 10, and two documents. Two participants withdrew from the study after theoretical saturation had been reached, and I had to undo the tentative conceptualizing to recruit replacement participants. I reached data and theoretical saturation after 12 interviews.

Data Collection Procedures

The primary data collection tools used were in-depth interviews, demographic surveys, and document examination. The data were collected through individual in-person and telephone interviews, and review of documents related to the orientation processes and procedures for expatriate nurses.

Intensive interviews. According to Wolgemuth et al. (2015) qualitative interviews can be paradigm-driven, where the questions and questioning have theoretical and epistemological underpinnings. Because this study used the constructivist grounded theory approach to study a group of nurses engaged in professional integration in a different country, I used constructivist interviewing to collect data. Charmaz (2014) posited that constructivist interview practices consisted of mutual construction of experiences from the interaction and collaboration between the researcher and research participants. Paradigm-driven interviewing practices such as the constructivist type focus on the interviewee and permits them to be heard, empower the participants, and have a therapeutic effect (Charmaz, 2014; Wolgemuth et al., 2015). This approach to interviewing was ideal for eliciting information from individuals trying to fit into a new

and different society such as the expatriate nurses in this study. Charmaz (2014) added that constructivist interviewing's focus on the participants' tone and method of answering questions encouraged the interviewer to formulate their questions in a way that drove the theory generation. This strategy was used and observed in the data collection process in this study, and some questions were rephrased, and the order of questions was at times changed in response the participants' answers.

The interviews were semi-structured, with open-ended questions that invoked the generation of rich and thick data because the questions permitted the participants to speak freely. Such questioning and data generation enhanced the transferability of the research findings (see Rosenthal, 2016). The telephone interviews were audio taped and then transcribed verbatim for data coding and analysis. The notes from the in-person interviews were expanded and also stored in NVivo. Grounded theory requires some participants to be interviewed more than once to create categories, and this information was included in the consent form and highlighted to the participants in the discussion on dissertation requirements. Debriefing sessions lasting about 20 minutes were held by telephone with participants who decided to exit the study after data collection and analysis had been completed, and I reminded them that there would be no repercussions from their withdrawal. I did not take back the coffee voucher I had given them after the interviews.

Face-to-face interviews. In-depth face-to-face interviews were conducted using open-ended singular questions and follow up probes to facilitate the generation of both intensive and extensive data (see Rosenthal, 2016). The initial interviews were conducted

face-to-face. Each initial interview session lasted between 30 to 90 minutes. Rosenthal (2016) argued that the quality of interview data depended on careful and strategic formulation of the research questions to include experience or behavior, sensory, opinion or value, knowledge, feeling, and demographic questions. In this study, experience questions were asked first, followed by sensory questions, opinion or value questions, then knowledge questions, and finally feeling questions to answer both the overarching and subquestions. Demographic questions were not asked, as they had been addressed by the demographic survey. Doody and Noonan (2013) also concurred that in qualitative semi-structured interviews the questions should follow a logical flow, but the researcher can alter the sequence of the questions in order to follow emerging paths not planned for initially.

Face-to-face interviews allow the researcher to note non-verbal cues and also to create a context for the data collection process. The participants did not want me to audiotape the in-person interviews. Copious notes were therefore taken during the interviews, describing the participant's demeanor and other non-verbal cues, and I took care not to interfere with the participants' responses or my incidental observations. The participants were encouraged to ask questions for clarification.

Telephonic interviews. The telephone interviews were conducted with those participants who do not wish to participate in face-to-face interviews for anonymity or other purposes. The participants were interviewed from a place in which they could feel safe and at ease, but away from their workplaces to avoid disrupting their work commitments. Most of the participants opted to be interviewed when they were in the

comfort of their own homes. Arrangements were made to avoid disruptions and intrusions by their family members. Telephone interviews were also conducted as a follow-up with previously interviewed participants to clarify some points, and to fill out the emergent analytic categories.

Although grounded theory studies generally incorporate non-verbal communication in their data (Ward, Gott, & Hoare, 2015), the telephone interviews were not intended to be the main data collection tool as the visual cues are absent. Mealer and Jones (2014) posited that telephone interviews were ideal for researching sensitive topics. The research question required the expatriate nurses to describe their leaders' behaviors and styles; in this study the telephone interviews were ideal to elicit rich and deep data from responses to the sensitive questions. In-depth, semi-structured interviews were conducted using open-ended questions to elicit the rich and deep data. The interview protocol guided the questioning to avoid digressing from the research questions, but was flexible enough to permit probing the emerging new leads. Ward et al. (2015) argued that in contrast to face-to-face interviews, telephone interviews encouraged the participants to think more deeply before responding. This aspect of telephone interviews helped to compensate for the absence of non-verbal cues in this situation. In line with grounded theory research method, the participants were informed that they could be interviewed more than once to follow up on unclear data or for theoretical sampling purposes, and most of them were happy to do that. This information was also included in the informed consent. I had informed the participants the time the telephone interviews would take, and I ensured I did not to go beyond these time limits.

Document observation. Charmaz (2014) asserted that extant documents were a rich source of information, especially for grounded theorists who could examine the form and content of data. Documents examined consisted of orientation programs for internationally recruited nurses. Other extant documents such as appraisal forms, personal diaries, and the evaluation forms completed by the expatriate nurses in respect of the orientation programs in place at the healthcare organizations were not available for review.

Demographic survey. A demographic survey was used to capture the participants' general and work history, educational background, and their length of stay in the UAE. This information helped to validate the participants' inclusion criteria, and also contributed to the data collection procedure as back ground information. Participants who met the inclusion criteria were selected for the interview part of data collection.

Follow-up plan for participant recruitment. In this study I used two sites for data collection. I had intended to use three research partners in the initial plan. In case the recruitment process resulted in fewer participants than intended another hospital that met the inclusion criteria would be used. I had approached and sensitized another private acute care hospital of this possibility at the same time I approached the other hospitals for participation in the research. When some research participants withdrew from the study and I could not get replacement participants from my current research partners I contacted the Walden University IRB for change of research plan. I sent the necessary documents the new hospital required, but before they gave me approval to recruit participants, I got four more participants from my initial research partners.

Variations from Original Data Collection Plan

My original plan was to collect data from three sites, but I ended up using two research partners. The other variation was that my original a priori sample was 20 to 30 participants, but my final sample size was 10 research participants and two reviewed documents. Thirdly, in-person interviews were intended to be used for the bulk of the interviews, but the majority of the participants preferred telephone interviews. Rudestam and Newton (2015) warned researchers to be aware that the dissertation process was unpredictable and could change any time and in ways unanticipated by the researchers.

Data Analysis

In grounded theory data collection and analysis are done concurrently using the constant comparative method (Corbin & Strauss, 2015). The in-person interview data were expanded from the interview notes as soon as was feasible and uploaded into NVivo. The telephone interviews were either transcribed verbatim and then uploaded into NVivo, or uploaded as audio into NVivo and transcribed from there. Early transcription helps the researcher to incorporate important information gleaned from incidental observations (Maxwell, 2013) such as non-verbal communication and the interview context, and ensures accuracy of information. Data from the notes and memos I generated enabled the explanation of some aspects of the information. The transcribed data were then read through several times to gain a general knowledge and understanding.

Linking Research Question to Data

Questions one through four derived data from the in-person and telephone interviews as the questions explored the research participants' perceptions,

interpretations, descriptions, and thoughts. The research questions required the participants to describe their perceptions of the lived experiences in the new work environment. To answer questions five through seven interviews and document reviews were used to elicit the data. The last three research questions required both the research participants' perceptions and descriptions and what the organization and the nurse leadership did towards the orientation of the expatriate nurses. For example, the orientation programs included activities pertinent to nurses newly arrived into a different culture, such as the cultural immersion program offered by one participating hospital.

Data Coding Strategy

The constant comparison method was used for data coding, where I moved iteratively between collecting data and analyzing data in a form of a spiral between the four coding phases used in this study. Initial, focused, axial, and theoretical coding as described by Charmaz (2014) were used to develop the codes, categories, and core categories that would contribute to the inductive and abductive generation of a theory and the knowledge needed to explain how nurse leadership styles and behaviors influenced the professional integration of expatriate nurses. Data analysis was conducted through the creation of different hierarchies of nodes in NVivo.

Gerund-driven coding. I used gerunds in the initial, focused, axial, and theoretical coding to help me to start thinking analytically from the participants' perspective. According to Charmaz (2014), rather than coding for topics and themes, grounded theory researchers coded with gerunds to look for actions and processes and to stay close to the data. In addition, omitting gerund-driven coding from the words and

actions of the research participants resulted in a grounded theory that "... reflects an outsider's rather than an insider's view" (Charmaz, 2014, p. 121).

Initial coding. In this phase, all the transcribed data were coded using line-by-line technique, sentences, paragraphs, and specific incidents as reported by the participants (see Charmaz, 2014). In addition, initial coding gave a name to portions of data and helped me to make sense of what was happening in the data in terms of who, what, when, and how. The interview data and the data from documents review were initially coded to identify and conceptualize processes and how they are constituted, and this guided me on which codes to further explore and expand on.

Focused coding. In this phase I selected the codes that occurred frequently during the initial coding and construct new codes for larger segments of data, and also derived new gerunds that described best what was happening in the data (see Charmaz, 2014). This type of coding revealed the most important concepts emerging from the data in comparison with the initial codes and newly collected data.

Axial coding. The tentative analytical codes and categories developed through focused coding were then organized into categories through axial coding, where relationships were identified among the properties of these categories (see Charmaz, 2014). Initial coding deconstructed the data, whilst axial coding reconstructed the data. Axial coding contributed to consolidating and filling out the tentative analytic categories and themes that would in turn contribute to developing the emergent theory.

Theoretical coding. I used theoretical coding to consolidate the analytic frame developed so far through the preceding coding phases. According to Charmaz (2014)

theoretical codes gave form to the subcategories and categories and illustrated their inter-relationships. The categories developed from axial coding were then integrated to form core categories through theoretical coding and theoretical sampling. This coding phase informed the emerging theory and made it more coherent.

Qualitative Data Analysis Software

Qualitative data by nature generates copious amounts of data that could lead to data overload if not managed effectively (Rudestam & Newton, 2015). NVivo, a computer-assisted qualitative data analysis software package distributed by QSR International was used to organize and manage the data for analysis. I selected NVivo because I have used it previously and am quite comfortable with it. My other reason for using NVivo was due to its versatility with managing, storing, and organizing different types of qualitative data such as interviews, surveys, and audio-visual data (Rudestam & Newton, 2015). NVivo was used to transcribe the data and then code them, and also for storage of data from the interviews, reviewed documents, and also for organizing the demographic details of the research participants. Methodological and analytic memos were created in NVivo and linked to the portions of data they were derived from, and were also used to develop the emergent analytic and conceptual codes and categories.

Issues of Trustworthiness

Trustworthiness of a research study pertains to the quality of the research findings, whether those findings were actually a result of the qualitative inquiry (Houghton, Casey, Shaw, & Murphy, 2013; Santiago-Delefose, Gavin, Bruche, Roux, & Stephen, 2016). There are several methods and models of ensuring rigor in qualitative

research, and in this study I used Lincoln and Guba's (1985) trustworthiness criteria that includes credibility, transferability, dependability, and confirmability (Houghton et al., 2013; Lincoln & Guba, 2013), reflexivity, and grounded theory-specific measures of quality as described by Charmaz (2014). Reflexivity and the grounded theory-specific methods of assuring quality of research findings are described in Chapter 4.

Credibility

Credibility refers to how truthful the data are, and how far the researcher ensures the data are believable (Cope, 2014). I used triangulation to maximize credibility of the research findings. Method triangulation of in-depth individual interviews, demographic survey, and document examination; and data source triangulation, where data were collected from two acute care hospitals, were used in this study (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). Theory triangulation of Meleis's (2010) transition theory and the full range of leadership model also added to the credibility of the study (Lincoln & Guba, 2013). Initial interviews took between 45 to 90 minutes to ensure prolonged engagement in the research field. The summaries of the interview transcripts were given to the research participants for member checking and to confirm that the data were a true account of the interview session. Data collection, constant comparison, and theoretical sampling were continued until theoretical saturation was reached (see Charmaz, 2014). To improve my interviewing skills prior to the actual interview process I practiced the interview exercises in Janesick (2011). Finally, credibility was enhanced through reflexivity, which is the self-reflection and intentional acknowledgement of the researcher's biases, ontological and epistemological stances, and their sociocultural

situation in the research context (Engward & Davis, 2015). Reflexivity was conducted through writing researcher memos. I have also acknowledged in this study that I am an expatriate nurse to inform the research consumers that I share an experience with the population under study; and how my theoretical standpoint affected data collection and interpretation.

Transferability

Transferability is defined as the extent to which research findings from a study can be applied to a similar context (Cope, 2014). Thick description through open-ended questions and semi-structured interviews (see Lincoln & Guba, 2013; Patton, 2015) ensured the data I collected contained as much detail as possible so that readers and other interested parties could perceive a connection with the research context and content. The high number of research questions in my study assured rich and thick data. Selecting participants from different donor countries also promoted transferability of the study findings. The Philippines and India, the major donors of expatriate nurses to the UAE, were fairly represented in the sample and consisted of more than half the total number of the research participants.

Dependability

A research study is said to be dependable if the findings show consistence and the possibility of replicating the study in similar situations (Cope, 2014). An audit trail of the research process was done through keeping methodological and analytic memos describing the steps of the research process, and how analytic decisions were reached. Reflexivity by the researcher and participants also increased dependability of the study,

and in line with grounded theory tradition I used memos to record my thoughts, biases, and preconceptions (see Charmaz, 2014). According to Houghton et al. (2013) the data analysis software package NVivo enabled the maintenance of an audit trail through the query tools function. I used this tool on two occasions to review my nodes.

Confirmability

Confirmability is the accuracy of the data, the extent to which the researcher shows that the research findings are indeed data generated from the participants' responses and not from researcher bias or the researcher's interest (Houghton, 2013). I sent a summary of the interview transcripts to each participant for them to validate the data before I analyzed the data. Audit trails and reflexivity were used to maximize confirmability. I maximized the confirmability of the study findings by reducing bias through including research participants from both the developing and the developed countries.

Ethical Considerations

Any research study involves as certain degree of risk to the participants (Patton, 2015). Ethical and legal stipulations require researchers to protect as far as possible, the rights and safety of the research participants. Approval to conduct research was sought from the Walden IRB whose standards demand adherence to the guidelines and procedures for ethical human research. My research partners required me to obtain Walden University IRB approval before they could grant me permission to collect data from their expatriate nurses. The reason was that the hospitals did not have research ethics committees in place prior to my request for research partnership. I obtained

conditional IRB approval from Walden University, which I used to get IRB approval from the research partners. The signed letters of cooperation were used to get full IRB approval from Walden University. My Walden University approval number was 02-23-17-0352193, and the approval expiry date is February 22, 2018.

The National Institutes of Health (NIH) certified me in protecting human research participants in December 2014. I had to renew the NIH certification because one of my research partners wanted the certification to be less than three years old. My research study was conducted outside the United States. In addition to adhering to the Walden university international research guidelines, I also had to comply with the research standards stipulated by the United Arab Emirates health ministry, the Dubai Health Authority, and the Health Authority Abu Dhabi. I familiarized myself with the UAE regulating authorities' human research protocols prior to applying for Walden IRB approval in order to reconcile the two protocols. The participating hospitals also had their own research guidelines to be complied with. The formulation of the letter of cooperation with a research partner (see Appendix D) and the informed consent form included recommendations from the research partners.

Accessing the Research Sites

Permission to access the research sites was sought from the chief nursing officers of the identified acute care hospitals. In one hospital, I was advised by the chief nursing officer to escalate to a higher official, the chief medical officer, the request for permission to conduct research. I sent the CNO my dissertation prospectus by email and then followed that up with a meeting with the respective chief nursing officers. During my

meetings with the CNO I gave each of them a full explanation of the study, and highlighted the possible benefits and risks to the organization and the participants. This was done to comply with the ethical principles of beneficence and justice. The participating hospitals had no ethics committees in place, so they took time to form those before they could allow me to collect data. The research partners agreed to use the letters of cooperation and data use agreement (see Appendix E) I had developed, but they asked me to adjust the forms to include their requirements.

Treatment of Human Participants

According to Rudestam and Newton (2015) research studies should be valid to avoid wasting participants' time. The findings from this study could add to the body of knowledge of nursing by understanding the expatriate nurses' process of professional integration, considering the prevalence of transnational migration. Participation in the study was voluntary, and the ethical principle of autonomy was observed through providing and documenting informed consent for all the participants (Rudestam & Newton, 2015). The participants were asked to sign an informed consent after a detailed explanation of the study has been given. Potential research participants who filled out the demographic survey were informed about the informed consent to participate in research. I discussed once again the contents of the consent form with the expatriate nurses I had selected to participate in the study. I asked them to read and sign the consent form before the interviews were conducted. I also signed the form and gave each participant a copy to keep.

The participants were informed that their names or other identifying demographics would not appear anywhere on the research report, and that raw and analyzed data would be kept securely in respect of the principle of beneficence. I reassured the participants that pseudonyms, in this case flower names, would be used on the raw data. Participants were informed that they were free to withdraw from the study at any time without any repercussions. The limits of confidentiality were explained to the participants to emphasize the trust relationship that would be maintained and expected to prevail during the study. This relationship had the potential to predispose to ethical issues, and I kept reflexive memos to record my thoughts and biases related to the study, and my status as an expatriate nurse who had also experienced professional integration. I informed the participants that I would be available to answer questions and clarify any misunderstandings. I also disclosed my status of being an expatriate nurse to the participants.

Ethical Concerns Related to Participant Recruitment

I did not collect data from my place of employment, but from two hospitals I am not associated with either professionally or socially. E-mails inviting participation in the study were sent to potential participants in the selected hospitals were facilitated by the office of the CNO. The expatriate nurses were not classified as vulnerable populations because they came to the UAE voluntarily on a professional status and through official recruitment. In my recruitment of participants, there was no way I could know or ask if any of the female participants were pregnant, and I included that fact in the application

form for Walden University IRB approval. Participants were not coerced in any way, but were invited to join the study of their own free will.

Treatment of Data

Research participants should come out of the research situation without any harm; which could be social, psychological, cultural, or emotional harm (Maxwell, 2013; Rudestam & Newton, 2015). To protect the participants, data were stored securely through NVivo on the researcher's password protected computer, only accessible to the researcher. Backup of the data were stored on a secure electronic tablet and two flash drives that were kept in my password protected safe only accessible to myself. Pseudonyms in the form of flower names were used to label the data to protect the identity of the participants. The data transcribed from the documents that were examined were also treated the same way as the human units of analysis, where identifying aspects were removed. The data from the documents were labeled as Facility A and Facility B, respectively, and the data were stored securely in a locked safe and in NVivo on my password protected personal computer.

Summary

Chapter 3 provided a description of constructivist grounded theory research tradition, the rationale for its selection, and the researcher's role in the study. I also described in depth how the research was carried out, including the sampling technique, recruitment and selection of participants; and the justification for the size of the sample. Data collection methods such as interviews and document examination were also discussed, as well as a description of the data collection protocols. This was followed by

a discussion of the data analysis and interpretation. Finally, ethical considerations such as autonomy, and methods of ensuring qualitative rigor, for example credibility, dependability, among others, were outlined. The results from the study are presented in Chapter 4.

Chapter 4: Results

The purpose of the constructivist grounded theory method was to develop a theory that explains the interactions between the nurse leadership styles and behaviors and the professional integration of expatriate nurses. In this chapter, I present the setting for the study, the participant demographics, data collection and analysis strategies, the results from the study, and the links between the key themes and categories from the study. The explanatory theory is grounded in data derived from in-depth interviews conducted with eight expatriate nurses recruited from different countries. The data were generated through the overarching research question "What is the perception of the expatriate nurses on the effectiveness of a nurse leader's styles and behaviors within a multicultural work environment in which expatriate nurses are integrating into the workforce?" The following subquestions were used to guide the study:

RQ 1: What are the lived experiences of expatriate nurses in a new work environment?

RQ 2: How would you describe the ideal multicultural work environment that would promote the professional integration of expatriate nurses?

RQ 3: What leadership qualities would enhance the integration of expatriate nurses?

RQ 4: What do you perceive as the key roles of a nurse leader in the professional integration of expatriate nurses?

RQ 5: What are the general experiences of expatriate nurses as they integrate into the destination healthcare organization?

RQ 6: What specific interactions with nurse leaders impacted on the expatriate nurses' integration process?

RQ 7: To what extent did the organizational cultural and structural factors influence the expatriate nurses' integration process?

Setting

The setting for this study was at two acute care hospitals in the two major emirates of the UAE. Although most health care institutions in the UAE employ expatriate nurses, there is a larger concentration and more ethnically diverse population of such nurses in the acute care hospitals. Requests to conduct research were sent to 10 acute care hospitals across the UAE, but only three agreed to have me collect data from their expatriate nurses. The CNO of each hospital was contacted through email and permission was sought to approach the expatriate nurses and to view their documents related to orientation of new nurses. One hospital was undergoing a merger at that time and later withdrew from the study. Document analysis was done on site because the hospitals were not willing to release copies. The expatriate nurses were contacted through e-mails, and those who were interested in participating in the study were sent a demographic survey form to complete.

The demographic survey form served as a screening tool to include and exclude potential participants. The demographic survey form was sent by e-mail to both the telephone and in-person interview participants. Those who met the inclusion criteria were then contacted by telephone to discuss the purpose and requirements of the study. The participants who did not meet the inclusion criteria were sent an e-mail to explain why

they could not be included in the study, and they were thanked for their interest in participating in the study. A consent form was sent by e-mail for signing by the participants who opted for telephone interviews, followed by the arrangement for the interviews. The consent forms for the in-person interviews were given to the participants, the contents were discussed, and the form was left with the participant to be signed. The interview arrangements were then made over the phone, and the participants were asked to select a day and time that was suitable for them.

Ten initial and two follow-up interviews were conducted either in person or by telephone and were audiotaped. The two participants who had in-person interviews declined to have the interviews audiotaped, so notes were taken during the interviews and were later transcribed. Each participant was given a $13.00 coffee voucher after the interview. All the identifying information was removed from the memos and transcripts, and each participant was given a pseudonym from flower names, for example Daisy. The audio files and documents were stored in NVivo on a password-protected personal computer.

Demographics

The 10 participants and documents for review were drawn from two acute care hospitals in the UAE, as shown in Table 1. The research sample consisted of nine female participants and one male participant. The participants' years of nursing experience ranged from 4 to 20 years, and the ethnic origins included Europe, Africa, and Asia. Table 2 shows the demographics of the 10 expatriate nurses who met the inclusion criteria, filled out the demographic survey form, and participated in the study. Purposeful

quota sampling was done to ensure India and the Philippines, the major donor countries of nurses to the UAE, were equitably represented in the sample. Robinson (2014) suggested using quota sampling together with purposeful sampling to ensure all the participant groups are fairly distributed in the final sample. The participants represented a wide range of clinical areas including medical, surgical, intensive care unit, delivery rooms, and emergency room.

Table 1

Source of Participants/Documents

Source	Number of participants	Number of documents
Facility A	3	1
Facility B	7	1

Table 2

Characteristics of Research Participants

Characteristic	Number of participants
Gender	
Male	1
Female	9
Years of nursing experience	
2-4 years	1
5-10 years	6
Over 10 years	3
Racial/ethnic identity	
Indian	3
Philippino	3
Arab	1
European	2
African	1
Religion	
Muslim	1
Hindu	3
Christian	4
Buddhist	1
Other	1

Data Collection

A total of 10 expatriate nurses participated in the study, three from India, three from the Philippines, one from Africa, one from the United Kingdom, one from Ireland, and one from Jordan. Registered midwives showed interest in participating in the study but were rejected because they did not meet the inclusion criteria of registered nurses.

Four other nurses filled out the demographic survey but did not respond to setting up the interview dates and times after multiple attempts to contact them. My plan was to collect data from at least three acute care hospitals, but the third hospital withdrew from the study.

Data were collected from April 10, 2017 until July 14, 2017. Orientation programs for new employees were analyzed from Facility A and Facility B at the hospitals, and clarifications and explanations were sought from the respective chief nursing officers (CNOs). The contents of the documents were inspected and transcribed on site, and I was not allowed to take copies or pictures. I could call the CNO to seek explanation of the document contents, and I called each of the CNOs twice to get more insights into the orientation programs.

The research participants were given the option of having either an in-person or telephone interview, and eight participants opted to have telephone interviews. Before the interviews, I reiterated the purpose of the study and reminded the participants that they were free to withdraw from the study at any time without any problems. The participants were also asked for permission to record the interviews via an audio recording device. At this point, privacy and confidentiality of the data was highlighted.

The telephone interviews took between 45 minutes and 1 hour, were audio-taped, and were later uploaded into NVivo where verbatim transcribing was done. Two of the participants were re-interviewed for about 15 to 20 minutes to clarify some points from the initial interview and to seek theoretical saturation of the emergent tentative codes. The interviews were audio recorded and transcribed verbatim. The telephone interviews

were conducted from my home where the door was locked to protect the privacy of the conversation. The in-person interviews lasted between 60 and 90 minutes, were transcribed in Word documents, and were uploaded into NVivo for analysis and coding. The interview venue was a secluded table outside peak hours in a quiet restaurant, and the two adjacent tables were booked to ensure privacy of the conversations. Detailed notes were taken during the two in-person interviews because participants declined to have the interviews audiotaped. Memos were generated after interviews to gather my thoughts on the data, and after coding to direct my process of conceptualization of the emergent codes and categories. The memos were then attached to the respective transcripts in NVivo.

Variation in Data Collection Plan

My initial plan was to collect and analyze data over a period of 2 months. The main challenge was that it took longer than this because the recruitment of research participants was slower than anticipated. A number of potential participants showed interest in participating in the study, but they later sent e-mails stating they had decided not to participate. E-mails were sent to invite participants to the study, but despite my sending follow-up invitations to potential participants, they took a long time to respond. I eventually managed to get enough participants to achieve theoretical saturation after 5 months. Two of the research participants decided to opt out of the study after theoretical coding was almost complete. Their wish was respected, and the interview transcripts were removed from NVivo and the generated codes were deleted and the audio records of their interviews were deleted from the audio recording gadgets. This meant the tentative codes generated by that point had to be undone and the data sets rearranged and coding

redone. Invitation e-mails were sent out to recruit more participants to enable data and theoretical saturation. Four expatriate nurses volunteered, and because they met the inclusion criteria interviews were arranged. The four telephone interviews were conducted and audio taped and transcribed verbatim according to the plan described in Chapter 3.

Data Analysis

Data were analyzed using the constant comparative method of grounded theory in which I went back and forth with data collection and analysis. I immersed myself in the data and compared data with data and incidents with incidents in a rigorous manner before moving on to more conceptual codes. I kept an open mind to derive deeper insights from the data, as suggested by Charmaz (2014). In keeping with the constructivist grounded theory tradition, I analyzed the data through initial, focused, axial, and theoretical coding phases. Theoretical sampling was done from the focused coding phase up to the generation of the substantive theory.

Qualitative Data Analysis Software

I used NVivo, a qualitative data analysis software system to store, organize, and assist with data analysis. Memos were also generated through NVivo and were stored in the specific portals. Interviews were transcribed from the audiotapes in NVivo prior to analysis. The software package also helped me to store the participants' demographics into specially provided containers and eased the process of developing tables to depict such information. Coding was also facilitated through NVivo where focused codes were developed as parent nodes and the related initial nodes were organized under the parent

nodes as child nodes. In addition, NVivo enabled me to identify frequently occurring codes at a glance and to generate and store in vivo codes.

Initial Coding

In this first phase of coding, I focused on line-by-line coding after reading through the interview transcripts several times to understand how the participants perceived the phenomenon under study. I deconstructed the data through line-by-line coding, breaking down the data and assigning names to each line. Gerund-driven coding was done to enable coding for actions and not topics, as described by Charmaz (2014). I did the same for each interview and the extant documents that I reviewed. I looked for patterns in what the participants were saying, searching for meanings that were not explicit. I compared data with data and scrutinized what the participants were saying to understand their experiences from their perspective. From there I linked the codes to other codes that were similar, reconstructing the data into hierarchies. For example, I placed the initial code "feeling culturally isolated" and "experiencing cultural clashes" under the same parent node because they possessed similar attributes. In vivo codes were also used, such as "we the non-Westerners." I coded my observations during the in-person interviews (Charmaz, 2014) and derived codes such as "externalizing frustration" when one participant was wringing her hands as she described her frustrating experiences in the new work environment. Such observations were included in my memos to be looked out for in the other participants.

Focused Coding

The second coding phase involved coding my initial codes after comparing them with other codes, and aggregating them into parent nodes in NVivo, or under new higher-level nodes. Focused coding is the process where the researcher identifies codes that are significant and have a higher analytic power, and uses these to analyze fresh data to create higher hierarchy codes or subcategories. I compared the initial codes with data from new interviews whilst asking myself the question "Which of these codes best account for the data?" and asking what analytical story these codes told, as suggested by Charmaz (2014, p. 141). Coding at this point was done on segments of data and at times on whole paragraphs, and this led to my generating categories and subcategories. Conceptual categories such as "experiencing transitional anomie" emerged. As I moved deeper into analysis I started developing theoretical sensitivity and started asking myself what these categories indicated, and deciding which codes had the analytic potential of categorizing the data, and explaining what was going on in the data. I wrote more analytic memos to make sense of the emergent categories. To get more clarification on the emergent categories I conducted theoretical sampling by selecting literature articles that could explain the concepts. I also conducted follow-up interviews with some participants to gain more insights on the emergent categories. The last two interviews were done on theoretical samples to saturate the identified major categories.

Methodological and Analytic Memos

Memos were written immediately after each interview to reflect on what the participants were saying, as well as on the process of data collection. Methodological

memos were used for situations such as when I had to adapt my research questions to pursue a lead from the participants' information. Analytical memos were written during data collection and analysis through constant comparison to externalize and crystalize theoretical concepts, and to guide my subsequent coding direction. The analytical memos helped with the process of moving codes into categories, and were used to sort these categories and to explore the relationships among them.

Axial Coding

Axial coding is a process where a core category is identified and the other codes are organized around its axis according to how they are related to that core category. Axial coding was done to determine any relationships between the categories and subcategories. This phase was a continuation of bringing the data back into a coherent whole that I began in the focused coding phase. Although Charmaz (2014) felt that it was not imperative that a constructivist grounded theory researcher used axial coding, I applied axial coding to my data analysis process to help organize and synthesize the emerging codes, and to hone my awareness towards any new developments in the data. I identified the major category "acculturation and assimilation" in this phase as it seemed key to understanding how nurse leadership styles and behaviors influenced professional integration of expatriate nurses. I and began arranging the sub-categories according to their relationship with the major category, for example the causal conditions, context, intervening conditions, strategies, and consequences. Theoretical sampling continued during this phase. Some categories were renamed and others were subsumed by the emergent analytic categories as I continued with memoing.

Theoretical Coding and Theorizing

The final phase of data analysis, theoretical coding, involved linking the substantive categories and uniting them to form a theory that explained how nurse leadership styles and behaviors influenced the professional integration of expatriate nurses. The ability to translate the lived experiences of people into an understandable theory was what differentiates grounded theory approach from other qualitative research methods (Charmaz, 2014; Murphy et al., 2017). As I continued with saturating the properties of the major category with guidance from analytic memos, I found that acculturation was not really what the data were saying, and I finally shortened the major category to "assimilation." The excerpt from analytic code number five describes my conceptualization:

> The other thing I noticed from the data and emergent categories was that the most thing the expatriate nurses wanted was to utilize these conditions to 'fit' into the new work environment. I then conducted theoretical sampling to explore the category properties deeper and achieve theoretical saturation. The major category acculturation and assimilation was developed. As I continued to theoretically sample and recoding the new and previous interviews I realized that acculturation was not what the expatriate nurses were describing, as it inferred adopting or borrowing the cultural attributes of the host society. What the data told me was that what the nurses alluded to was more of adapting into the new environment. The major category then became "assimilation."

Evidence of Trustworthiness

Trustworthiness of qualitative research findings is essential for the validation of the study findings, and the extent to which those study findings can be trusted and be valid for the intended consumers. The trustworthiness of the study was verified through observing credibility, confirmability, dependability, and transferability as proposed by Lincoln and Guba's (1985) criteria of trustworthiness and reflexivity. The criteria of credibility (truth or validity of the findings), confirmability (the research findings are a true reflection of the participants), dependability (the ability of the research study to be replicated), and transferability (the extent to which the research findings can be generalized or applied to similar situations) are used in qualitative research to ensure rigor during the research process as well as rigor of the complete research product (Cope, 2014; Lincoln & Guba, 2013; Morse, 2015).

Credibility

The credibility of my study was increased by spending considerable time that ranged between 30 to 90 minutes collecting data and engaging with the participants (prolonged engagement). After each interview, member checking was done, where a summary of the interview transcript was given to the research participant for review and verification that the transcript was an accurate representation of the interview. In addition, triangulation of data sources, where data were collected from two acute care hospitals, and method triangulation of semi-structured interviews and document review, were used to enhance credibility. Direct quotations and in vivo codes were used during data analysis to capture accurately what the participants said.

Confirmability

Reflexivity was done through writing memos at every stage of the research process to capture my thoughts and in which I reflected on my relationship to the phenomenon under study and kept in check possible biases. An audit trail was kept through NVivo, where all the memos, coding procedures, data sets, and participant demographics were stored. I conducted coding queries through NVivo track the development of my codes and categories. Using triangulation of data collection sites and data collection methods also added to the confirmability of the study findings.

Dependability

The dependability of this study was ensured through verbatim transcription of the interview data and asking for an explanation and clarification of the extant documents that were reviewed. The research process was described in detail at every stage to enable future replication of the study. This description included the sampling techniques, participant recruitment strategies, obtaining IRB approval for international research, use of the demographic survey for participant screening, data collection and analysis process, and finally theory development through induction and abduction. Follow-up interviews were conducted with some participants to seek clarification of certain data parts. Memos were also used to record my interactions with both the data and the participants. I revisited my codes to ensure they had been coded correctly and recoded as necessary to ensure intracoder agreement.

Transferability

Transferability refers to showing that the research findings can be applicable to other similar contexts (Creswell, 2013). Transferability in this study was enhanced by purposefully sampling the research participants from a well-defined population that shared life experiences of the phenomenon of interest. Quota sampling was added to ensure equitable representation of the population by ensuring that the major donor countries of expatriate nurses were fairly represented. I also provided thick description by describing in detail the research process, research design, sampling frame, the research setting, participant demographics, and data collection and analysis procedures, and the research findings. The research participants' ages and years of nursing experience spanned across a broad range, thereby supporting transferability of the research results.

Reflexivity

I was actively reflexive during the data collection and analysis process and acknowledged that my perception of what the participants said and what I observed during the in-person interview sessions was dependent upon my previous experience and interpretation of the phenomenon under study. Throughout the research process reflexivity was exercised by being on guard about any possible bias, preconceptions, and assumptions I could bring to the research situation. I wrote analytic memos after each coding phase not only to guide my theorizing but also to keep my preconceptions in check. I also made explicit to myself my previous experience with the phenomenon under study and deliberately held at bay any possibility of that from influencing the data collection and analysis.

Grounded Theory-Specific Evaluation Criteria

In addition to the four criteria for evaluating trustworthiness and rigor of qualitative studies, my study also used the criteria for evaluating the quality and rigor of constructivist grounded theory as described by Charmaz (2014). I ensured the study has resonance and usefulness.

Resonance. My findings resonate with the study of the expatriate nurses' experiences in the host country and work environment. There is also a link between the individual nurses' experiences and the multicultural nature of the acute care hospitals of the UAE, in the sense that most of the expatriate nurses came from generally monocultural societies and struggled to adapt to the culturally diverse work places. Categories such as adopting coping strategies illustrate the human instinct of self-preservation when people perceive a threat to their wellbeing, in this case the unfamiliar work environment.

Usefulness. There are some insights that emerged from the data such as the lack of leadership styles relevant or specific to multicultural workplaces in the UAE, and yet the population in the UAE and GCC at large consist of about 80% foreigners. These findings can be used by healthcare organizations to drive leadership development programs.

Study Results

The results section is organized according to the seven research questions. Nursing research is still in its infancy in the UAE and most hospitals have never had research studies conducted either by their own nurses or external researchers, I therefore

asked my participants why they volunteered to participate in my research study. The reasons for participating are presented before the results.

Reasons for Participating

Most of the research participants had never participated in a research study before, and cited curiosity and wanting to learn about research as some of the reasons they volunteered for this study. The other reason was that the expatriate nurses were interested in discussing their experiences during the transition period into their UAE experience and contributing to the research findings. The participants who have experience in research studies cited as the main motivator their wish to contribute to the scientific field of nursing. For example, Rose stated, "It is every professional nurse's responsibility to contribute to the advancement of nursing through research."

Document Analysis Findings

The documents I examined and analyzed were orientation programs for the new staff. Other documents such as appraisal forms and feedback form from the new nurses were said to be confidential and were not available for examination. The participating hospitals did not have orientation programs specific to nurses only, but were designed as general orientation programs for all new employees. While Facility A had a more robust orientation program for new nurses that included a cultural immersion session where the new nurses were taken around the local historical sites, visits to the villages, the museum, and had a chance to meet the local people. The human resources department also discussed the UAE culture and the Muslim religion and advised the new nurses to

observe these local cultures to avoid offending the UAE people. Facility B had a brief orientation program of new staff to the UAE healthcare organizations.

Research Question 1

What are the lived experiences of expatriate nurses in the new work environment? The participants were asked to describe their experiences when they arrived to the UAE, the different aspects between their home country and the new work environment, during their first few months in the new hospital.

The participants described different experiences during their first few months in the UAE. In general, the new nurses experienced anxiety because of the unfamiliar country and a general fear of the unknown. The unfamiliar work practices also added to the anxiety and culture shock. A consistent theme that emerged was "comfort zones." The categories related to this theme were family and social support structures and developing survival skills. The participants relied on different forms of support system and certain coping strategies they perceived as lifelines for surviving the first months in the host country. These comfort zones were where they went to for solace and recovery.

Family and social support structures. Most expatriate nurses felt their coming on their own or with someone greatly influenced their first few months in the UAE. They felt having someone with whom to verbalize their concerns and worries minimized the anxiety. The majority of the newly arrived nurses reported that the human resources department arranged their mobilization, and a hospital representative met them at the airport. Despite this action that helped them to settle into the new organization, the expatriate nurses stated that having someone they knew in the host country made a

greater impact. The need for support structures as comfort zones was not found among the younger expatriate nurses only, but the mature nurses also sought emotional support. The fact that the expatriate nurses were in a foreign country evoked feelings of insecurity and a perceived sense of threat that in turn stimulated the need for a lifeline such as a family support structure. Camellia, an experienced nurse from Ireland said:

> I have never been here before, but I came with a friend of mine. We kind of had each other and talked to each other, and that was good. But I think the fact that I have come here with a friend has made it a lot easier, and I don't know how I would have felt if I was on my own. It would have been a completely different experience.

Jasmine, who came to the UAE alone, mentioned that if she had brought her husband and children her first few days in the new country would have been much easier. At the time the interview Jasmine's family had come to the UAE and the family was together. Dahlia, whose father encouraged her to join him in the UAE added, "Having a family member here really helped me to adapt and cope with the unfamiliar environment." Even those nurses who did not have family ties for emotional support reached out to people with whom they shared common ground such as their fellow country people. According to Daisy, even strong-willed individuals needed to socialize to minimize the stressors associated with transnational migration:

> I am an easygoing and strong person and I looked for people from Jordan and went out with the people from my country outside and we smoked Shisha and we talked and they were really helpful in my early days here. Life here is very tough

> when you arrive because everything is new and you do not know anyone. So spending time with me other Jordanians helped me a lot. I met these people through one Jordanian colleague here and it was better after that.

The responses from the participants seemed to point to the assumption that humans naturally sought and found comfort and security from social relationships. Some innovative ideas were developed as people sought out these vital social relationships. For example Camellia mentioned that the new staff at her facility formed a WhatsApp group through which they reached to colleagues for emotional and psychological support:

> The girls I have been working with have been great and we have a WhatsApp group with them and the new staff and everyone has been open. If you aren't feeling great and you send them a message, any of the girls would call you, ring you and say let's meet up or go for coffee or something like that. I feel that is important because you definitely need a support group like that especially for me where everything is different from what I am used to.

The UAE is a multicultural society and the Muslim laws are not as strict as in the other GCC countries. As a result the expatriate nurses were expected to experience minimal anxiety. With more than 200 nationalities residing in the UAE it was generally assumed that migrant workers transitioned easily into the host society. The experiences reported by the participants negated that assumption.

Developing survival skills. Some participants experienced difficulties in their work environments and resorted to developing coping strategies as survival skills. Misunderstandings and miscommunications with their colleagues, cultural clashes with

both staff and patients, caused distress among the expatriate nurses. For example, Camellia said:

> Sometimes I kind of find it difficult because maybe one of my opinions of what I would normally do at home might not be what one of the nurses would do. So in that kind of situation it may be difficult to work well.

The new staff members had just had a positive experience with joining the health care organization, unit-based orientation programs, but were then facing negative experiences on the clinical units. Some of the expatriate nurses were not sure how to deal with the conflict, and used avoidance to avoid worsening the situation and would not escalate their conflict to the relevant people. “I was afraid she would think I was reporting her, and I did not want to get into trouble,” Jasmine stated. For Iris, a nurse from the Philippines, a defeatist attitude was the best way of survival, “I tried to adjust although it was difficult at first to be here, but I just did whatever they wanted me to do and I followed all the rules and process flows.”

In contrast though, the experienced nurses dealt with the conflict by talking things over with the concerned colleague, for example Camellia said, “That definitely took its toll on me for a little while but after that I have talked to that particular team leader that was on that shift. She agrees with my feelings.” Whatever the method, the participants all used some form of strategy to cope with the uncertainty of the first few months in the new work environment. The core categories and themes for my first research question are presented in Table 3.

Table 3

Key Themes and Categories for Research Question 1

Key theme	Categories	Selected excerpt
Comfort zone	Family and social support structures	Having a family member here really helped me to adapt and cope with the unfamiliar environment (Holly)
	Developing survival skills	One really needs to have strong coping mechanisms within yourself because if not you are likely to lose the battle. Sometimes I would socialize with others outside work, or go out with friends, I mean just be sociable. (Dahlia)

Research Question 2

How would you describe the ideal multicultural environment that would promote the professional integration of expatriate nurses?

The question addressed the perceptions of the expatriate nurses regarding the ideal work place that would support their integration, and one that would impede the integration process. The rationale was to place the integration process in the UAE and GCC context of multicultural work environments alongside the nursing leadership. The expatriate nurses interpreted their experiences in the new multicultural environment as where they lost their identities, had their professional status relegated to that of a novice nurse, and endured abuse from colleagues and patients while the organization's

leadership looked on. The key theme "transitional anomie" and the categories from this question are illustrated in Table 4.

Transitional anxiety. All the participants experienced transitional anxiety in varying degrees when they were first exposed to the multicultural work environment. According to Petunia, the staff members in her organization were from at least 30 countries, and the patients from at least 50 countries. The contributing factors to anxiety included lack of support systems, language barriers, differences in the organizational culture and structure. In addition, the expatriate nurses reported feelings of inadequacy related to the different practices, feeling undermined, unfamiliar interpersonal relationships, perceptions of cultural isolation, lacking rights, and bullying. The participants felt overwhelmed trying to get accustomed with the newness of it all (Dahlia).

There was also a perceived fear of making mistakes and getting reprimanded or punished, and most of the participants verbalized such fear. Talking about such fear, Oleander said, "I have seen some people terminated for simple things, for example if a patient complains about you, especially the Emirati patients if they complain you will be terminated." This fear exacerbated the expatriate nurses' anxiety. Iris shared the fear of losing her job in relation to making professional decisions, where she felt if nurses took their accustomed autonomy for granted they could lose their jobs. She stated, "But in here I cannot just immediately decide for something and the atmosphere is kind of strict and we know that a single mistake that we make, hum, our employment is at risk."

Culture shock. There still were surprises and unexpected experiences even though the nurses came to the UAE fully informed about the religious limitations and the culturally diverse societies. Some of the participants discovered that what they had envisaged what not what they encountered, and it took some time for them to deal with the culture shock. (Lily). With regards to the cross cultural interpersonal relationships, the communication channels and hierarchies in the new work environment, Camellia's response was:

> It's difficult to get my head around it. I think it is hard to settle into a multicultural environment at the moment because we have Indian nurses, Filipinos, South Africans, Jordanians, and myself from Ireland, UK, so there is quite a big range of cultures.

Bullying: Some participants experienced bullying in the nursing units, perpetrated mostly by the doctors. The bullying had been reported to the unit leader by the time of the interviews with the research participants, and was under investigation by the unit manager. Dahlia said, "But some of the other staff were really bullies." According to Lily:

> The other problem we have is the attitude of the registrars on the unit because they bully us and treat us like their servants and they send us around but they do not do that with the other nationalities for example the South Africans and the British.

Lacking rights. Another factor associated with transitional anxiety was the perceived lack of rights, where the participants were afraid to speak out against any

perceived injustices. The expatriate nurses felt the lack of rights instilled fear and that hampered their integration into the hospital. When people had no rights then they could not stand up for themselves and were prone to abuse and maltreatment by others. Rose alluded to this point as:

> What would concern me is maybe the lack of rights that I am used to as a nurse and as an employee of an organization. Do the staff members here in the UAE have the same rights as I would have in the UK? That's one concern.

Institutional discrimination. Discrimination is interpreted as being treated unfairly or differently due to certain life circumstances or certain attributes. The expatriate nurses were exposed to discrimination in one form or another in their first months in the health care organizations. Hospitals were stress-filled workplaces and the discrimination added to the new nurses' anxiety and exacerbated the perceptions of transitional anomie. Although the UAE was a highly multicultural country, the levels, incidences, and frequency of discrimination was a culture shock to the new nurses. They were under the impression that the UAE society was tolerable of different people regardless of their situation or circumstances (Lily). Camellia stated, "Like they would make you feel like you are not the same as everybody else."

The discrimination was considered as more negative when perpetuated by the individuals who were supposed to facilitate the expatriate nurses' integration into the unit, that is the nurse leadership. The new nurses expected support and cultural sensitivity from their leaders but felt disillusioned when they instead were discriminated against, and found it difficult to settle into the new work environment. According to Dahlia:

> But she had a tendency to prefer others; I mean our leader the charge nurse would favor some people over others. We were not treated equally; well, like some nurses would be supported and others were not. If it were not for that leader I think I could have enjoyed my stay there. The manager was ok at times but sometimes she would treat us unfairly, but not as much as our charge nurse.

The expatriate nurses also reported discrimination in the form of different salaries and job grades for the different nationalities. Different nursing contracts were designed for Western-educated and the rest of the nationalities, and the salaries for the Western nurses were higher, although the nursing roles and responsibilities were the same. (Lily). Some patients were prejudiced against the nurses, but they could not do or say anything or even escalate the discriminatory actions for fear of losing their jobs if the patients complained against them.

> And it is very painful for us. Can you imagine going into a patient's room and you introduce yourself and they ask you if there is a British nurse on duty as they were told we have British nurses in this hospital. We can't say anything because the patient is always right and we need our jobs. Only Westerners are recognized in this hospital, I do not know about other hospitals. (Jasmine).

Some participants, however, believed that not all the patients treated them unfairly, and felt the local UAE people were more accommodating and respectful of the multicultural nurses regardless of where they came from. (Lily).

Disregarding previous experience. Nursing skills are transferable across different divides, which is why nurses can gain a professional license to practice in other

countries (see Walani, 2015). Nurses took professional pride in their level of experience and their stage in the novice-to-expert nursing model, and felt offended and disrespected when they were placed on the same grade with newly graduated nurses (Oleander). In addition, the expatriate nurses were not happy that the practice in the some of the hospitals in the UAE was to place new nurses on the same salary scale, as long their job title was registered nurse. According to Rose this was not right and there needed to be a standardized system to recognize the nurses' prior nursing experience in the form of remuneration and grading.

> One thing I found that is missing is having across the board consistent tier structures in the UAE. You need that. We have what we call banding system in the UK and Ireland, and that is very helpful in that people understand that if they are coming in at this level these are the wages they can expect. This is widely varying in the UAE, and is not helpful for the workforce. You get an increment after your appraisal when your line manager says this person has done well, or after two years with re-contracting, and I think they should make it standard. (Rose).

The more experienced nurses had the uncomfortable situation of working under nurses with less experience that they had. Nursing was considered hierarchical by nature and sometimes nurses were promoted to higher posts based on their years of experience and proven leadership potential. In some of the hospitals in the UAE that was not the case and nurses were promoted because they had stayed longer in that organization, although they had no proven clinical expertise. Camellia stated, "Some of the team leaders here

have not even looked after women with complicated obstetric conditions, and they need to understand that we may be new to the UAE but we are not new to nursing."

Some of the participants regarded the clumping of all nurses into a single category or grade as contributing to deskilling because they could not perform the roles they were used to in their home countries. The expatriate nurses felt they could not be as innovative as they wanted because they were regarded as inexperienced nurses who could not make clinical decisions.

> I feel this makes our work difficult because we are not allowed to think for ourselves and we have experienced such cases back in our own countries but here it is like we are new to nursing. In India we are allowed to make decisions for ourselves and discuss with the doctor and we can then just document what we have done. For example if my patient complains of pain I can give him Panadol and just inform the doctor and there is no problem but here you cannot even give such a simple medication without a prescription from the doctor because the policy does not allow. Out thinking capacity and making decisions is reduced here, I feel. (Oleander).

Table 4

Key Themes and Categories for Research question 2

Key theme	Categories	Selected excerpt
Transitional anomie	Transitional anxiety	You see when new people come and join they are very anxious and tense due to the new work place and they are not aware of the routine and what to do in certain circumstances and all that makes them very tense. (Petunia)
	Institutional discrimination	And it is very painful for us. Can you imagine going into a patient's room and you introduce yourself and they ask you if there is a British nurse on duty as they were told we have British nurses in this hospital. (Jasmine)
	Disregarding previous experience	We are new here but where we came from we have many years of experience, sometimes even more than the people here and that is my case. I discovered that the people who were refusing to help me in the first days are now asking me to help them with some difficult procedures because they now know I have been exposed to such cases back home in India. (Oleander)

Research Question 3

What leadership qualities would enhance the integration of expatriate nurses?

The question required the participants to describe the qualities they expected nurse leadership to exhibit and use to help them to integrate smoothly into the new workplace. Several expected qualities were brought up and it was interesting to note that leadership from the participants' perceptive differed. There was a general agreement among all the participants that favorable leadership qualities were required to propel the organization forward, and negative qualities impeded organizational success. The main leadership qualities desired by the expatriate nurses included reliability, clinical expertise, authenticity, transformational skills, considerate, and cultural sensitivity. The participants focused mostly on the leadership qualities that would impede their transition. The reason was that they were anxious they would not achieve healthy professional integration and settling into the new workplace. The key theme from this question was called "ineffective leadership is a barrier." The following were the categories related to the key theme.

Some leaders can shoot you down. The participants described the qualities they would like to see in their leader, for example traits such as confidence, compassion; roles such as coaching and guiding; behaviors such as keeping an open door policy and approachability, among others. A leader was supposed to uplift the followers and not bring them down, to listen to their opinions, to build them up and nurture them so they could themselves develop into leaders. Camellia felt discouraged by the leader who would not listen to her ideas and thwarted any suggestions:

> I suppose rather than just say no I am wrong, I get discouraged from discussing or making plans. I feel sometimes some of the team leaders can shoot you down a little bit rather than listen to what I have to say, and listen to my own opinion or my own concerns. In that respect if I knew someone was going to treat me like that I wouldn't feel comfortable going to her if I had a problem, which isn't a good thing. You need to feel comfortable with your team leader, particularly if there is something wrong.

For Petunia, clinical expertise was key to effective leadership, and she felt a leader who could not role model astuteness was not fit to lead a team of critical care nurses. Petunia pointed out, "The team leader should be skilled to assess the patient's conditions and then assign the staff accordingly." For some participants a strict leader was regarded as ineffective and obstructive by some expatriate nurses, and other participants like Dahlia perceived being strict as a strength a leader should have to exert some control in the unit:

> I think the leader should be stricter; there is a rule that English only should be used in the workplace but still these nurses still continued to speak in their own language. They were not really strict, but were very lenient and allowed it and did not stop them.

Other expatriate nurses saw stability in a crisis as an essential quality that encouraged integration of new nurses, and they stated that nurses felt comfortable and reassured when their leader was confident, stable, and reliable for guidance. Newly arrived nurses did not feel reassured if they saw their leader as vulnerable and failing to

manage a crisis situation. They needed to know that they were in a place where the leader was in control and could be relied upon to solve any problem. For example:

> But one thing I have noticed here is that some of the team leaders if an emergency situation arises they can get quite panicked and that can transfer onto everyone else. Obviously you don't want that in an emergency situation, you need someone to be just calm, to delegate so that everything is done smoothly. (Camellia).

Poor leadership qualities were considered detrimental to the health of the work environment, the staff, and the welfare of the patients. Some leaders shouted at the nurses in front of patients and made the patients uncomfortable and anxious, and some expatriate nurses attributed this to inexperience with leadership.

> Our manager was a staff member before and she has been here for about eight years, and was labor room staff. The previous manager was strict but she was ok with us. The manager now is new to the position and she has never had such a position before. When she treats people I don't think she gives people opportunity because in terms of leadership I don't think is a good leader, maybe she is a good manager but she not a good leader. She never encourages you to do your stuff, for example we are busy in the labor rooms here and even if you have a patient and you are with the patient she will just shout from outside the room. She will just call you even if you are busy and ask you "Did you do this?" or "Did you do that" and stuff like that. That makes the patients anxious.

The participants felt that if a leader addressed the expatriate nurses with respect and spoke politely to them then the new nurses learned to trust themselves, and this

maximized their self-belief of navigating the uncertain terrain of the new work environment.

Improving the leader-follower relationship. The leader-follower interaction was cited as one of the problematic areas during the expatriate nurses' first few months in the clinical units. The majority of the expatriate nurses observed that there was a need for an improvement to that dyadic relationship. The major contributory factor to the poor leader-member relationships was the lack of good communication skills. The leader used toxic communication styles such as shouting in public or in front other people. This was a universal undesirable among the participants. For example,

> The team leader started shouting at me and said I was refusing to take the patient and I was doing my work slowly deliberately. I was very upset because she told me this in front of my patient and I felt that was not right. I did not say anything in front of the patient but I called her aside later and told her to learn how to communicate. I am not a child to be treated that way and she should learn to be a leader and behave like one. That day I felt very unhappy but I hope she will never do that again because leaders are supposed to communicate well with staff and listen to them and assess the situation first before blaming them. Such behavior destroys the morale of the staff. (Daisy).

The other matter that came up with regards to the leader-follower relationship was the leadership behavior that compromised that relationship that in turn made it difficult for the newly arrived nurses to adjust into the new unit. When the new staff member was trying to find ways to survive the transition into a new place they needed positive

leadership actions by the leader to motivate them and give them the confidence and support they need. The new nurses needed nurturing, as explained by Oleander:

> Autocratic leaders do not build a team but they destroy the confidence of the staff and people do not want to be treated like children, we are professional nurses and we have worked in other places before. New nurses here should not be treated like they are new to nursing because they are new in the hospital. A leader who does not consider that the staff know about nursing and only need to learn the new routine and new system make it difficult for the new nurses to integrate well.

Still on the matter of a healthy and facilitative leader-follower relationship, some nurses felt that the leader should have cultural sensitivity, to consider each staff member as an individual, and then tailor individualized supportive and orientation strategies.

> I want a leader who will see me as an individual who should be given attention as an individual because I am from a totally different country from the other colleagues. I am not saying I am different or special, but that my experiences and needs are different from the others, every one of us has different needs and we deal with stress differently. (Daisy).

Feeling undermined. The new nurses felt they should be treated as the professionals that they were, and pointed that any leadership behavior that undermined them would not be effective in motivating them to learn the organizational culture and to fit in. A leader was supposed to consider the level of expertise of the nurses and take on board their previous nursing experience (Iris). Leaders were expected to exhibit behaviors that contributed to the personal and professional growth of the expatriate nurses, a form

of leadership that was capacity building, and that did not demean them. The leader should treat them as autonomous individuals and include them in decision making on matters relating to the unit and extra duties.

> Usually when the top management send messages to us like can we do some new work our in-charge will immediately say yes without talking to us first, but he will not be affected by the extra work and yet it is us who have to bear the extra burden. That is why he will immediately say yes. Maybe sometimes he could also speak on our behalf, and some of the work of the in-charge is also delegated to us. I think he can do it but if he is going to delegate his work us, maybe he is busy, but for us, hum, of course nobody likes additional work. (Iris).

Although the nurses were new they had to be treated as part of the team, and as people who were responsible for the future and success of the unit. A leader seeking to drive the unit towards meeting the organizational goals had to treat the followers as part of the unit and consider them as having an interest in seeing the unit succeed. (Rose). In addition, the participants argued that by respecting the expatriate nurses' professionalism and not undermining them, the leader promoted staff retention. According to Daisy, an experienced nurse:

> I do not want to be treated like I am a junior nurses because I am new to the UAE. I want to be treated with respect and considered that I have many years experience and I am only new to this hospital. Some leaders can forget that and start treating you like a junior when in fact you were also in a leadership position back home. It is very discouraging to be treated like that you know.

The key theme and the categories from research question 3 are shown in Table 5.

Table 5

Key Themes and Categories for Research question 3

Key theme	Categories	Selected excerpt
Ineffective leadership is a barrier	Some leaders can shoot you down	I feel sometimes some of the team leaders can shoot you down a little bit rather than listen to what I have to say, and listen to my own opinion or my own concerns. (Camellia)
	Improving the leader-member relationship	A leader needs to be able to manage the unit, for example if she is too strict people can be scared of her. I mean when a leader is strict even when I want to ask something or I have a problem I will feel scared to approach her. We cannot be free when our manager is very strict, the atmosphere will be very tense and we will be wishing she were off duty or to sit in her office only. (Jasmine)
	Feeling undermined	I understand things are done differently out here, but that does not alter the fact that I am experienced with looking after laboring women back home. Some of the team leaders here have not even looked after women with complicated obstetric conditions. So yes, a leader who does not consider my previous experience and would hamper my adapting to the unit here. (Camellia)

Research Question 4

What do you perceive as the key roles of a leader in the professional integration of expatriate nurses?

When I asked the participants about the specific roles a leader should play to facilitate the integration of expatriate nurses, the key theme "Facilitative leadership behaviors" emerged from the data. The participants considered leadership behaviors as composed of leadership roles, and did not feel any single leadership role was enough to effect influence in any situation. The expatriate nurses believed leadership behaviors consisted of leadership roles, qualities, and characteristics. Some of the factors that influenced the expatriate nurses' process of integration were cited as both good and bad leadership behaviors. Participants felt they were more likely to transition easier if their leader facilitated that by valuing them as professionals and supporting them.

Leadership qualities and characteristics. The participants recognized that the leader in a workplace was responsible for influencing the environment, and that included setting the tone for the integration of the expatriate nurses. To describe what they referred to as good leadership the participants specified the desired leadership qualities and characteristics that would fit their interpretation of the construct. The positive and negative attributes of a leader were defined to support the dynamics of leadership behaviors. The participants were precise with the features and attributes they associated with good leadership behaviors that facilitated their professional integration process. Conversely, the negative leadership behaviors were regarded as inhibiting the integration process.

Goal-setting. One of the qualities that were required of leaders was to be able to set goals and then lead and motivate the team to achieve those goals. The nurses felt that if a leader set the goals and people were aware of those goals they would feel empowered and strive to achieve those goals. As a result the new nurses would not need a lot of guidance since they knew what was going on. In addition, the autonomy and creativity of the new nurses were stimulated, as Holly explained, "We are new here, yes, but if we are told what is going on then we can take responsibility and plan to achieve what the leader wants." A leader who set goals was seen as being focused and visionary, and that resonated well with the newly arrived nurses who derived comfort from the sense of purpose. (Dahlia). Oleander agreed that a leader who set goals was able to effectively guide the team and the unit as a whole towards the achievement of the goals, and associated the setting of goals with quality improvement.

> My manager has the good qualities and each time I am with him I admire his leadership skills and we are lucky to have such a manager really. I would say my manager has democratic leadership qualities because he does not accuse us or blame us but he asks us nicely what happened and helps us to learn from our mistakes and assists to correct our mistakes and that is very professional behavior. A leader should act as a role model for the staff, be there for them when they need help, and show them the direction and set goals for the improvement of the unit.

Giving support. Another critical quality of a leader was support for the newly arrived nurses. At this point in time most of the expatriate nurses were still in the throes of transitional anomie and struggling to find their feet and bearings. A sense of comfort

and feelings of being acknowledged were attributed to supportive leadership. (Lily). Leadership support was also seen as alleviating the anxiety and hopelessness they were going through, and giving them the hope and encouragement that was crucial for survival in that situation. Speaking of support, Rose stated,

> The leadership behavior they gave to the staff was born of support because when they arrive here the nurses lack confidence in the new place. They made sure the nurses knew that they were supported, and also knew that they had in place certain professional standards that they wanted people to strive to achieve.

The expatriate nurses viewed the use of preceptorship as the epitome of leadership support. They felt the preceptors acted as a bridge through which they crossed to the other side that was the new work environment (Petunia). The preceptors introduced them to the new ways of doing things and facilitated their navigation of the unfamiliar nursing territory of the UAE. The relationship with their preceptors was regarded as a lifeline, a psychological support structure, and even a survival method by some of the participants. For example, Daisy stated, "I was very happy that they gave me a preceptor who worked with me and was my shoulder for support and worked with me for about two months. During that time I was taught all the routine in the unit." Petunia agreed, "The new staff should be given a preceptor to help them and support them and help them to become competent in their care of patients and they should help them to learn everything." Nurses like Dahlia also regarded preceptorship as a capacity building relationship, "And also most of the skills that I have I developed them with her assistance, training, and

encouragement. She influenced me to do everything perfectly and correctly the first time, and quickly without wasting time."

Communicating effectively. The ability to communicate effectively was frequently cited as a desirable quality every leader should have. This was particularly highlighted in relation to the multicultural leadership situation. The general feeling was that people wanted to be treated as individuals, and that meant sensitivity to the different cultural communication orientations. Daisy indicated this point when she said, "I want a leader who will see me as an individual who should be given attention as an individual because I am from a totally different country from the other colleagues."

Being considerate. The participants expected the leader to be accommodating of the different personalities and professional backgrounds of their followers in view of the vulnerable state of being new. According to Daisy, the leader could also consider extenuating circumstances when dealing with conflict or discussing issues with the followers, rather than just blaming them without listening to their side of the story:

> She then told me not to worry and she would speak with the doctor but she asked me to be more careful in future and double check if any of the doctors had any special orders for their private patients. From that day my respect for the manager grew so much that I said to myself I do not want to move somewhere else and work under a bad manager. I knew our manager was good but I did not know she had such excellent leadership and communication skills.

Motivating staff. Several participants mentioned motivation as an essential quality a leader should possess, the rationale being the stressful nature of professional

integration into a new workplace. Motivation contributed to the promotion of self-esteem among the transitioning nurses. “The leader should be able to motivate the staff to perform better and praise them for the hard work” (Daisy). The participants expressed a need for positive reinforcement whenever they did something and stated they needed to be appreciated and to have their efforts acknowledged. According to Petunia,

> When the patient was stabilized and was on a ventilator my in-charge spoke to me and told me he was very happy with the way I had handled my patient and the emergency. That made me very happy that he was appreciating my work and I was only new and I was tense at first but I have experience in ICU nursing and I am used to handling cases like that. But I was glad that my in-charge motivated me and after that I tried very hard to make my patient care even better.

Idealizing leadership roles. The participants described the ideal roles a leader should play to facilitate the smooth transition and healthy integration of expatriate nurses. The leaders were seen as playing a pivotal role in the expatriate nurses first few months in the nursing unit. How the leader played out their roles determined the extent to which the new nurses managed to acculturate to the new work environment. Lily stated:

> When the new nurses come they want to be guided on the routines in the unit and to be shown how the hospital works and a leader should be able to do that. She should be there for the new staff, support them, and make sure they are well oriented by their preceptors. Also she should give the new staff good preceptors who will teach them well because some preceptors are not interested and they don’t teach you anything.

Problem solving. The other role a leader was expected to play was that of problem solving, and the leader needed to be able to deal with the problems that arose. "We are very busy here and we want a leader who knows what they are doing and can deal with issues and listen to us when we go to them with problems or requests." Speaking of problem solving, the leader should be approachable so that the followers could be confident with going to the leader with problems. (Iris). "So that if I had a problem I would feel ok and comfortable going to them and say, look I am not happy, or whatever." (Camellia).

Advocacy. Standing up for the staff was another role the leader needed to play because of the complicated nature of culturally diverse work environments. The nurses felt the leaders should be their voice with the hospital management. The nurses did not have forums where they could speak to the management directly, as pointed out by Iris. The leader was expected to take what the nurses were asking for and present that to the management. "Maybe he can try to speak for us to the top management." The nurses also expected the leader to advocate for them when they had misunderstanding with someone senior, and to help them offset the power differences. "When I had a misunderstanding with one of the registrars on our ward, my manager did not support me, and she did not stop the doctors from bullying me and the others." (Lily).

Negative leader characteristics. In addition to factors such as cultural exclusion, the negative leadership behaviors were cited as inhibiting smooth transitioning and seamless integration into the new work environment. The participants described both the negative leadership experiences they had had and those they would not like to encounter.

The main poor leadership quality mentioned by the participants was poor communication skills, where leaders did not exercise self-restraint with verbal abuse of the nurses. "Shouting in front of patients is not very professional," Lily pointed out. Another concern was that the leaders encouraged cultural exclusion by allowing some nurses to speak in their own languages in the presence of other ethnic groups. (Dahlia). These particular ethnic groups did not consider the comfort of their ethnically different colleagues, even in the presence of the nurse leader.

> Maybe our in-charge should be strict with making English the only mode of communication because, um, especially in the endorsement in the morning or any other shift they are endorsing patients in their own language. How can I understand the endorsement?

Some leaders demonstrated favoritism and nepotistic tendencies that included treating some nationalities better than others (Jasmine), denying some people their rights to requesting specific shifts and giving them instead to staff from his or her own country (Iris). Another action was culturally isolating some staff by speaking to staff members from their country in their own language and not considering the rest of the staff (Lily).

In summary, the leadership behaviors, roles, and qualities exhibited by the leaders in the context of professional integration of the expatriate nurses determined the success of that integration into the new work environment. Table 6 shows the key theme and the associated categories for this question.

Table 6

Key Themes and Categories for Research Question 4

Key theme	Categories	Selected excerpt
Facilitative leadership behaviors	Specifying desirable leadership qualities	Leadership qualities are important because a leader needs good qualities for them to lead people especially different nationalities and she needs to build a team and not destroy the team. (Oleander)
	Idealizing leadership roles	Now what the new nurses need is a leader who will welcome them and make them feel at home, you understand, and show them and explain to them the new routines and how to communicate with others such as the laboratory, pharmacy, and others. (Oleander)
	Negative leader characteristics	That is not how a leader should behave instead she should wait until you have finished with your patient and call you into her office and talk to you. Shouting in front of patients is not very professional. (Lily)

Research Question 5 (a)

What are the general experiences of expatriate nurses as they integrate into the destination healthcare organizations?

The question sought to address the experiences of the expatriate nurses in the new work environment in relation to the interpersonal relationships among the different work groups. The emergent key theme for question 5 (a) was "Breaking exception by inclusion."

When asked how the interpersonal relationships influenced their professional integration process the expatriate nurses described their experiences as being culturally excluded and isolated. The different groups were organized into silos and the group closure was obvious and the group members deliberately sought out their own and closed out the rest. The new nurses found it difficult to be accepted into these groups at first, but later certain factors facilitated and enabled breaking down of the silos and allowed the newly arrived nurses to be accepted into the groups.

Being culturally excluded. Nurses from some countries deliberately closed out those that were not from their own country. They would isolate that individual and not offer any assistance or answer queries. Dahlia said, "It was kind of difficult for me to fit into that environment to be honest because I was made to feel like an outsider." The excluded nurses found it difficult to learn the routine things on the unit, especially when their assigned preceptor was engaged elsewhere. The host nurses spoke in their own language in the presence of the other ethnicities. The use of language to exclude other nurses was experienced and expressed by all the expatriate nurses interviewed. "When

people speak in their own language you feel like an outsider and you are not confident to ask questions or to ask for help." (Oleander). Jasmine added, "Sometimes the Philippino and Indian nurses will be speaking to each other in their languages and I did not understand what they were talking about." Dahlia also experienced the same, "For example most of my colleagues were Indian and they would talk to each other in their language like you were not there." The official languages for communication in the UAE healthcare organizations were English and Arabic, but it seems this rule was not followed; the new nurses were excluded, and were not helped to integrate effectively into the new environment.

> The Indian nurses if they are together they sometimes speak in their own language, which is a bit difficult to grab. It is not all the time, for example they would not do it if they were discussing work but sometimes you feel a bit awkward if they are speaking in their own language because obviously you don't know what they are saying and things like that. (Camellia).

We, the non-Westerners. The organizational culture was such that nurses were treated according to their ethnic background. In consequence, the expatriate nurses attached labels they used to refer to themselves, for example "We, the non-Westerners" (Jasmine). Additionally, the organizations based actions and processes such as job categories, salaries and contracts on ethnic orientations.

Culturally divisive leadership. One observation was that some nurse leaders treated their subordinates unfairly and showed nepotistic tendencies towards nurses from their own culture. Favors and work related requests were granted according to the nurse's

cultural background, and the expatriate nurses faced challenges trying to negotiate days off with the nurse leader:

> We are nurses from different countries here, but the British ones are treated like they are special more than others. Even the duty roster they can complain to the manager and they get the shifts changed. They are listened to whenever they say anything. When the others nationalities complain or request a specific shift we are not entertained and do not get the same. Maybe it is because the manager is also British, I don't know. But it is difficult for us when we are not treated the same. Nursing is the same everywhere in the world, it is not the skin color that matters, but experience and skill. But here it is like skin color is more important.

Ethnic group silos. The different cultural groups stuck together in groups and closed out the other cultural groups. The new nurses who had no other colleague from their own cultural background found themselves isolated and struggled to adjust into the new work environment. Those who were represented culturally or ethnically on the unit managed to get support from the fellow countrymen.

> But sometimes the different nationalities stay together for example the Indians from Kerala like to sit together even in our staff room and we speak our own language and eat our food together it is same with the Filippinos and they also sit together and share food with other friends. (Oleander).

The general consensus among the participants was that even though the perceived ethnic silos served the group members well, closing out others discouraged the formation of teams and also impeded progress of the unit as a whole. The in-group and out-group

members felt isolated in some way and by closing out the other cultural groups they isolated themselves as well. The lack of camaraderie, effective groups and teams and the associated healthy interpersonal relations were yearned by the expatriate nurses. As Lily pointed out:

> Here we are not working you know like family, in the Philippines we have each other; we don't have that harmony here. People just work and do not worry about each other, we are not like family here and even the teams are not strong. I miss the Philippines where we all worked and treated each other like family. I feel that should be there as well here because it is very lonely here and we spend most of the time at work and we should be happy here.

Inclusion by acceptance. In some nursing units it was realized that the consequences and effects of groups closure and ethnic silos were uncomfortable for everybody in the unit. The participants were not exactly aware how this came about, but there were deliberate efforts by those affected to embark on forging relationships and liaisons between the different ethnic groups. The nurses deliberately worked at creating a rapport with those from different cultural backgrounds and accepting diversity. "As for the staff we learn to work together with them." (Petunia). Others came to appreciate the need for acceptance and mutual understanding necessary to maintain cross-cultural working relationships.

> Actually when we are working in multicultural workplace we have to respect each other and try to understand each other so that we can have good relations. It was

> not easy at first to try to work well with the other nationalities but we managed to get along. (Oleander).

Other nurses also agreed with accepting nurses into the unit and even developing friendships with them the best thing to do, and the new nurses perceived this acceptance by their peers as facilitating their integration into the unit. Iris stated, "I have some people from other countries that I am friends with rather than my Filipino friends, and I am closer to these other people than my Filipino people." The new nurses could seek help and guidance from their peers without being discouraged by the cultural differences. In other situations the nurse leaders took the initiative to encourage the nurses to be accepting of their peers despite the cultural divide.

> We all come from different backgrounds, different religions, different training, and sometimes I kind of find it difficult because maybe one of my opinions of what I would normally do at home might not be what one of the nurses would do. Our manager does not care about that and treats us as one team and we like that. (Camellia).

Table 7 shows the key theme and the associated categories that emerged from research question 5.

Table 7

Key Themes and Categories for Research Question 5 (a)

Key theme	Categories	Selected excerpt
Breaking exception by inclusion	We the non-Westerners	We the non-Westerners are treated differently like I said, and it's not fair. We feel the British nurses are the same like all of us. I am not saying they are bad people, but they think they are something special. (Jasmine)
	Ethnic group silos	Different nationalities here stick together and it was kind of difficult for me to fit into the environment to be honest because I was made to feel like an outsider. (Dahlia)
	Inclusion by acceptance	The staff should be discouraged from only helping people from their own countries and cooperate with other nationalities. (Oleander)

Research Question 5 (b)

Can you describe how the differences in nursing practice impacted on your integration experience?

The participants perceived that the different clinical practices between the host country and their home countries influenced their professional integration process in a significant way that required professional resocialization, the key theme for this question. The clinical practice paradigm the expatriate nurses were accustomed had to undergo a shift to enable them to fit into the new work environment. The process of professional

resocialization was reported as being fraught with challenges and also reaped rewards in terms of professional growth, acquisition of new knowledge and nursing skills.

Adapting clinical practice. The participants were recruited from different countries that had different methods of clinical practice. The health care organizations in the UAE derived their clinical practice guidelines from different sources such as the American, British, and European healthcare systems. The participants' main concerns in this situation included the expectation to practice under unfamiliar guidelines. Holly, a nurse from India, pointed this out in her response:

> It was a bit difficult for me when I first came here, I am used to the British guidelines in my home country where we base our patient care on the NICE guidelines. Here they use the American guidelines and that is very different from what I am used to. Sometimes I would find myself having to refer to the guidelines and policies just to remind myself on how to do a procedure. It was confusing for me.

The American clinical guidelines were described as being stringent and seen as emphasizing quality in relation to the standards and stipulated requirements of JCI. The nurses who came from different clinical practice orientations found this to be a source of pressure and described struggles with adaptation to the American clinical guidelines. The nurses also felt frustrated that they were expected to perform extra processes that they perceived as unnecessary and a waste of time.

> The patient care is very different and here there should be 100% good care all the time as per the JCI. For me it was the medication, like dealing with the high alert

> medications and narcotics as we have to double-check everything, and the documentation is a bit too much. We have to attend classes for the calculation of medications. We have to attend classes on a monthly basis to learn new things and this is all too much and in my country we did not do all this and it was all very simple. We also had to do the competencies for things that we already know about for example IV cannulation. (Petunia)

The British nurses felt uncomfortable working under the American system as they were used to working in nurse-led units, as alluded to by Camellia. " I feel the environment is more doctor-led, and coming from an environment that is mainly nurse-led, there is a huge gap here." Iris, from the Philippines, who also had to adapt her practice to suit the doctor-led work environment, echoed this.

Adapting clinical practice also involved the use of technology in nursing care and relearning clinical practice. All the participants, regardless of where they came from, had had to deal with unfamiliar technology and had to adopt new methods and modes of patient care.

Meeting new technology. Nurses from resource-limited countries found the technology challenging as they reported that the use of high technology in the hospitals in their countries was not yet widespread, especially in the small hospitals. Adapting clinical practice involved the difficult task of learning to use technology and other aides to use in their routine patient care activities. "I can say all things are different, because in Africa, in Nigeria to be specific, there is no technology like here. I did not know how to use things like infusion pumps and other equipment." (Jasmine).

Even the nurses who came from countries using some form of technology for patient care verbalized anxiety at having to adapt their care and start using presumably complicated technology. “The technology here is advanced I noticed it very different from India there we only have ordinary machinery and here we are using complicated triage protocols,” Oleander said.

The other nurses were worried that relying on technology could led to loss of hands-on patient care skills. There was also the premise that using technology did not always save time, but led the nurses to spend less time with the patients. For example Holly argued:

> The routine was new for example the technology here is more such as the electronic records and back home we still write on paper all the patients’ notes. It is easier to write on paper because we can take them into the patient’s room, whereas writing in the HIS takes more time and we are always too busy to sit down at the computer and start writing. By the time we write the notes we would have forgotten what happened. Anyway if we depend too much on technology we will lose our skills.

There was a disagreement though among the expatriate nurses, where some of them regarded the use of technology as a good thing and a sign of the advancement of patient care. Those who did not support the use of technology perceived a loss of control over their nursing practice, and those who embraced technology associated that with a sense of empowerment and capacity building. “But I will learn the machinery and I know I will learn many things here.” (Oleander).

Relearning nursing care. Adapting the clinical practice necessitated relearning some work-related activities and even nursing care. The relearning process was common across the different years of experience of the participants and frequently involved multitasking. Camellia had to relearn patient care by looking after more than one woman in labor at a time, "I'm finding it difficult to adapt to the work situation, back in Ireland I would have just the one woman to look after and that would be it. I wouldn't go anywhere else and would be with her all the time." Some nurses had to relearn nursing care by way of segregating patients by gender, as described by Oleander, "Another thing is that us male nurses are not allowed to attend to female Muslim patients and we should call a female nurse for that. In India we can look after all patients without any problems. The experience here is very different and we need to be careful and cause any problems for ourselves."

The other responsibilities that the nurses had to take on were the non-nursing roles, such as dealing with insurance for the patients under their care and calling the laboratory to follow-up on the blood reports.

> The unit is very busy and we need more staff to do the other duties like answering the phone, adding used items used to the patient's bill, and calling insurance department. If you forget to charge anything you used on the patient you get into trouble. (Jasmine).

Relearning nursing practice was seen as a positive thing by a few expatriate nurses, particularly those who had little nursing experience. They were happy to take on the extra roles and considered it as "doing more advanced work." (Dahlia).

Subjugated professional autonomy. Migrating to the UAE involved the loss of professional autonomy due to the different organizational ethos. The more senior nurses especially externalized this. In response to the aspects of the new work environment that were different from their home country practice Rose, an expatriate nurse with more than 10 years experience said:

> I would say nurses in the UK and Ireland have more autonomy and more independence in practice. And more so because especially in the public health system rather than in the private the nurses would do more advanced practice than nurses in the private sector would in the UK and Ireland.

Other experienced nurses such as Camellia echoed lack of autonomy in the new work environment as posing difficulties with adapting to the new work environment, in addition to different systems of clinical practice:

> I feel the work environment here is a lot more doctor-orientated, while back home in Ireland you are more independent and able to make your own decisions, and you will only consult a doctor if you have any concerns or you have any worries. Whereas here I feel like if you have to anything it has to go through a doctor, so I am definitely struggling with that aspect. In Ireland we go through different guidelines, and we follow the Royal College of Obstetricians and Gynecologists, whereas over here they follow the American guidelines, again which is something I am not used to.

To some participants, the different work environment was more than the actual work, but extended to the interdisciplinary relationships and the perceptions of each

discipline to the other. These nurses were used to be treated as equal partners in the nurse-doctor dyad, and struggled to accept having doctors talking down at them and ignoring the fact that nurses were professionals in their own right. Rose pointed out that:

> I would not say it affected me per se but I noticed that sometimes the expectations of doctors I wasn't comfortable with, I felt as if the nurses were undermined by the expectations of their role. They wanted an assistant rather than a nurse, and they perceived that the nurses should do that.

The nurses from the other countries also lamented the perceived stripping of autonomy and the limitations placed on their critical thinking and decision-making skills. Having to depend on the doctors for all the decisions was a sore point among the participants. They reported feelings of helplessness and regression to their junior nurses period. The participants stated that the worst thing any nurse could experience was the loss of autonomy and the ability to make professional and clinical decisions and judgments with relation to the patients under their care.

> I would give the medications on my own, but here I have to be with someone to give medications and we have to work together. For me it is difficult to work like that without freedom to think and act on my own. It is more strict and more limited here, I mean our autonomy, our movements, we feel we are always controlled and monitored, which may be fine but we do not need so much monitoring. (Iris)

Embracing workplace pluralism. Another way the expatriate nurses perceived professional resocialization was through acculturating to the culturally diverse work place

and embracing the different skills and unique experiences each individual brings to the work situation. The differences among the nurses bothered the new nurses at first as some of them were from predominantly monocultural societies and had never worked with nurses from other cultures before, as Jasmine explained, "I have never worked with British nurses or Indian nurses before and it was so hard to learn to communicate with them and ask them for help." The perceived chasm between the different cultural groups impeded healthy transition into the new work environment. Once these unique differences were acknowledged and considered as strengths and contributory parts of the team-building process, the participants reported feeling more positive and ready to be team players. According to Dahlia:

> I now see other cultures as very exciting and to work with different people. You know and learn the different cultures and it is kind of good to be giving care to patients and you learn and understand their culture. You interact with your patients and you then get an idea of what is happening. And it is very exciting to know people from different backgrounds like we have on our unit.

Table 8 shows the key themes and categories from research question 5 (b).

Table 8

Key Themes and Categories for Research question 5 (b)

Key theme	Categories	Selected excerpt
Professional resocialization	Adapting clinical practice	I can say all the things were different, as in Africa and Nigeria to be specific there is no technology like here. I did not know how to use things like the infusion pumps and other equipment (Jasmine)
	Subjugated professional autonomy	I feel the work environment here is a lot more doctor-orientated, while back home in Ireland you are more independent and able to make your own decisions, and you will only consult a doctor if you have any concerns or you have any worries. … I am definitely struggling with that aspect. (Rose)
	Embracing workplace pluralism	A lot of the mothers and mothers-in-law and grandmothers are not used to being in a hospital, strapped to a monitor and all these medications for childbirth. So you have to kind of meet them in the middle in that situation, which again is something I am not used to. (Camellia)

Research Question 6

What specific interactions with nurse leaders impacted on the expatriate nurses' integration process?

This question explored the leader-follower interactions and required the participants to describe a situation where they felt the leader positively influenced their

stay as well as one in which they felt the leader could have done more to promote their intent to stay. This was a key question that explored the direct leadership dynamics between the nurse leader and the expatriate nurse, albeit at a cross-sectional point. The expatriate nurses described the instances but the common theme that emerged was "Supportive leadership styles." These leadership styles were preferred above all the others because the newly arrived nurses needed support more than anything to transition into the new work environment. All the participants, regardless of their professional level, expressed the need for support from their leaders.

Experiencing affiliative leadership. In response to this research question, the participants highlighted that the perceived anxiety-provoking situation of trying to integrate into a multicultural work environment required a specific type of leadership. Moving to a new country, especially one that is a melting pot of cultures, required more than motivation and encouragement. The required leader ship style had to include support, compassion, and elements of transformational leadership. Theoretical sampling of the literature revealed that affiliative leadership styles were ideal for such situations. Affiliative leadership

- creates harmony and emotional bonds;
- people come first;
- emphasizes empathy, building relationships, and communication;
- heals rifts in a team, motivates people during stressful circumstances (Goleman, 2000, p. 83).

Affiliative leadership represented the type of leadership that the expatriate nurses alluded to when they described the leadership behaviors they would have liked to see in their leader. The attributes and uses of affiliative leadership were similar to what the participants described.

Some of the expatriate nurses recounted instances where they experienced support and individualized attention from the leader that helped them to deal with the transition. This support was seen as offsetting the discomfort of having to derole to a lower position on the nursing professional ladder. (Iris). Such gestures meant a lot to most of the expatriate nurses, and were cited as contributing to the decision to stay on the unit.

> I remember when I came she introduced me to the ward staff and showed me the geography of the unit, also the routine day-to-day activities in the unit, the weekly activities like ordering of stock and drugs for the unit, like checking of equipment rooms, the patient room, routine for day and night shifts, and also some patients' documentation, and also things like routine patient care in the unit. (Dahlia).

Some of the leaders' behaviors and attitudes towards the expatriate nurses, such as making them happy and valuing their welfare and emotional status evoked feeling of loyalty and commitment. (Lily). The leader's caring attitudes towards the followers was echoed by Petunia, "The in-charge should spend time with the new staff to make sure they are comfortable and to answer any of their questions."

There were yet other actions and leadership behaviors that were attributed to the success of the expatriate nurses' professional integration efforts that included empowerment of nurses, unit orientation, and keeping an open-door policy.

Empowerment of nurses. When the leaders showed empathy and developed a trusting relationship with the new nurses feelings of empowerment were stimulated and the nurses reported optimism. According to Rose, "And the leader should often encourage the nurses to try and find solutions themselves so that they could become more confident, more independent**."** The participants welcomed such affiliative leadership behaviors, and participant Oleander referred to trusting relationship between the leader and followers as vital and empowering:

> You see, people want a leader they can trust and who can lead them well and don't want to follow a leader who does not what he is doing. Nurses need to know they have a leader who can help them and teach them things they do not know and who will listen to them and treat them well and considerately.

Inducting new nurses. Induction programs for new nurses were viewed as key to paving the way for the smooth transition of the expatriate nurses into the unit. After the organizational orientation program the new nurses had an opportunity to learn the organizational structure and culture at the micro level. They were shown around the unit and learned the functions and dynamics of the unit to prepare for when they started working independently. (Holly). The induction programs were viewed as a vital activity that had the potential to ensure success with integrating into the organization.

> The new staff should be given departmental orientation should also be given to show them how the work on the ward is done and to show them the policies and protocols and guidelines. The new staff should only be given patients when they are competent and become familiar with the routine in the unit. The new staff

> should be given a preceptor to help them and support hem and help them to become competent in their care of patients and they should help them to learn everything. (Petunia).

The nurses who did not get any induction felt they had not been prepared adequately and therefore felt they were not ready to work on the units. Dahlia stated:

> When I joined I expected a company like with proper orientation for the staff. But during that time it did not happen, as there were few new joinees. So I was exposed to the ward without any proper orientation. So there was no real orientation, I directly went to the ward and worked**.**

Keeping an open-door policy. When the expatriate nurses experienced challenges with regards to trying to adapt to the new work environment they wished they had had easy access to the leader to derive emotional support. According to Daisy, "The leader should have an open door policy and allow the new staff to go and see her each time they feel they need to talk and reduce the stress."

Culturally intelligent leadership. Leaders in culturally diverse countries had the added responsibility of understanding how to lead followers from cultures different from theirs. Theoretical sampling to explore the core category culturally intelligent leadership revealed that leaders of multicultural workforces needed to try and understand as far as possible the different cultures of their followers to avoid conflict and cultural injury to the followers (Bealer & Bhanugopan, 2014). In addition, cross-cultural leaders were required to have a degree of cultural sensitivity to enable awareness that their perception of effective leadership was different from that of the followers.

The participants saw culturally intelligent leadership as facilitating their successful integration into the new multicultural workplace. Most of the expatriate nurses were aware of the cultural differences in leadership behaviors and expected their leaders to do the same. For example Lily expected her leader to realize that talking to her fellow countrymen in their ethnic tongue when the other followers where present was not acceptable leadership behavior. In response to the question that enquired about the qualities a leader should have to promote integration of expatriate nurses, Iris responded:

> A leader who is not controlled by his cultural and religious beliefs, one who will see everyone as the same and treat them fairly and not in relation to their nationality or religion, not by the color of the skin, not by the language they speak. Most of the time we feel like since our charge nurse is not from the same country like us we always feel like he favors his own people, especially with the day off requests, he will consider first the requests from his own people.

Culturally intelligent leadership also required the consideration of the differences in not only the cultural backgrounds, but also differences in the organizational culture orientations. Leaders needed to be aware that culture shock also occurred with regards to unfamiliar work practices. For example, Camellia, a nurse with over 10 years nursing experience, stated:

> I think sometimes some the leaders forget that I just arrived, that I am completely new to the country, the culture, the hospital especially, and if I am asking for advice they look at me as if saying why are you asking questions. Even though I am a qualified practitioner sometimes I still need a little more compassion.

Most of the expatriate nurses experienced some form or other of leader-inflicted cultural injury in their interactions with their leaders. Daisy perceived a lack of culturally intelligent leadership behavior by her leader when she said:

> The staff nurses here most of them were good but they should not talk in their language as we do not understand what they are talking about. In the early days they only grouped with their own people but later they started to talk to us but till now they talk to each other in their own language and we feel like we are outsiders. That should not be allowed and I though the manager would stop that but she did not.

Another critical factor was that nurses from different cultures construed what some leaders considered as acceptable behavior as nepotistic tendencies. For example, when the manager showed evidence of being closer to some staff members the other nurses perceived that as favoritism. (Lily). As a result the participants reported feeling some dismay and frustration and felt the leader could have done more to facilitate their fitting into the workplace.

The expatriate nurses experienced and perceived favorable conditions for integrating into the UAE acute care hospitals when their leaders exhibited and utilized supportive leadership behaviors in the for affiliative and culturally intelligent leadership styles. The key themes and categories for Question 6 are presented in Table 9.

Table 9

Key Themes and Categories for Research Question 6

Key theme	Categories	Selected excerpt
Supportive leadership styles	Experiencing affiliative leadership	I felt supported by my manager from the beginning and comparing my manager to the Path-goal theory I would say he is a supportive leader because he supports us even when we have done something wrong because blaming somebody only causes them to make more mistakes. (Oleander)
	Culturally intelligent leadership	I have talked to that particular team leader that was on that shift. I think actually sitting down and talking to her about it definitely helped, and rather than kind of shrugging it off and not coming back to see if I was ok or something like that. It was definitely good that she thought about it and came to realize that the situation I was in was a totally new one to me. That was a good thing. (Camellia)

Research Question 7

To what extent did the organizational cultural and structural factors influence the expatriate nurses' integration process? This question required the participants to describe their experiences in relation to the organization as a whole. The key theme for this research question was "supportive organizational climate."

According to the UAE labor laws prospective employees can only enter the country when the prospective employer has sponsored the employment visa, and that is

changed to a residency visa when the employee passes the medical examination. The residency visa is renewable every two years depending on the medical test examination and the agreement by both parties to renew the visa. The general feeling among the participants was that by facilitating the onboarding process and giving them support in the first few months the organization promoted and reinforced the expatriate nurses' intent to stay. Most of them felt they would renew their contracts with their hospitals.

Facilitating onboarding. Most of the participants reported that their organization had made their employment easier through facilitating on-boarding processes that would have otherwise been very difficult for the prospective employees. Some organizations used recruitment agents to seek out the expatriate nurses either directly from the donor countries such as the Philippines, or through online employment portals, and other organizations recruited through advertisements. The majority of the expatriate nurses had most of the necessary procedures such as nurse licensure and recruitment processes done on their behalf by the organization. The participants felt that being spared from the stress and financial implications associated with migrating to the UAE positively influenced they integration into the new workplaces. Highlighting this fact, Oleander said:

> Well, they helped to get the license when I had the eligibility letter. Here in Dubai you can't get a DHA licence without an eligibility letter, and the hospital has to sponsor the license, you understand. So my hospital did that for me and they transferred my visa to employment visa and I now have a residency visa. They did that for me.

Some of the visa and residency processes required visiting the different offices after prior bookings. When the hospitals facilitated this for the new nurses they were relieved and reported perceptions of organizational support. “During that week they organised everything for us, like the Emirates ID. It was all organised and we didn’t have to worry about all of that, which was very good,” said Camellia.

In addition the nurse licensure regulatory authorities and external accreditation bodies such as the Joint Commission International (JCI) required certain recommendations to be met if the new nurses were going to work in areas such as critical care. The participants felt facilitating all this and paying for the certifications would have put a huge strain on them. Some hospitals paid for the required certifications and then deducted the fees from the employees’ salaries at a later point, and other hospitals did not ask for a refund. This was another positive aspect of the on-boarding experiences mentioned by the participants. For example Oleander, an ER nurse, stated:

> And another thing, they gave me a refund of my air ticket from India because they recruited me from here and not from India and they gave me back my money and that was very good. They also paid for my BLS training too and my ACLS training because I work in ER you see, they will pay for all that and it was very easy for me here.

Speaking from the perspective of nurses who did not avail the facility’s assistance with the on-boarding process, Holly, a nurse who came to the UAE to live with her husband, still appreciated the support the organization offered, even though she voluntarily opted to be under her husband’s visa.

> I was on my husband's visa when I arrived so the hospital did not do that for me, and I did not want to change to hospital visa, but it was good thing that they have this offer for us.

The participants felt that by taking care of them in the initial days, the health care organizations gave them an insight into the possibilities of positive experiences they could look forward to. That first impression gave them a feeling of hope and helped to allay some of the anxieties inherent in migrating to a foreign country. Most of the participants used the terms hospital and hospital management synonymously, in a sense ascribing the perceived organizational support to the hospital management and the organization as a whole.

Promoting intent to stay. Intent to stay was referred to as the decision to stay with the organization for as long as one could and included renewing the employment contract and the residency visa. In response to question seven, some participants construed the influence of the organizational culture and structure as actions that promoted their intent to stay. The general perception among the expatriate nurses was that the organization went to a great extent to ensure the comfort of the staff and to smoothen the transition period. Most of the participants compared their experiences in their previous organizations in their home countries and stated that the hospitals in the UAE were sterling exemplars of staff retention and staff satisfaction. Petunia stated "I had hospital orientation and the HR explained everything for us and we knew what to do and who to see if we had any issues."

Visibility of the top management was also interpreted as reinforcing the welfare of the employees because in the expatriate nurses' home countries the top management did not mingle with the ordinary employees. Daisy highlighted this is her response:

> When we first arrived they arranged orientation for us. They explained the hospital routine and leave accrual and things like that. We also had lunch on that day with the hospital CEO and we were all very happy to eat with him. After that we went back to the wards and there we had unit orientation and they showed us the ward and the documentation and the HIS for entering patient information and documentation in the system.

Sometimes the hospitals did not conduct the orientation sessions for new employees regularly, and only conducted them when there were a certain number of employees to warrant the resources. Dahlia was frustrated with the lack of an orientation program, felt she could have benefited from such, and did not feel supported as a result.

> When I joined I expected a company like with proper orientation for the staff. But during that time it did not happen, as there were few new joinees. So I was exposed to the ward without any proper orientation. So there was no real orientation, I directly went to the ward and worked it was rather hard for me.

The documents from Facility A that I reviewed and analyzed was nursing orientation program for new employees. The orientation program covered several topics that included the organizational chart, human resources functions and policies, hospital information system, the history of the hospital, and patient confidentiality aspects. According to the CNO of Facility A, the nursing orientation program aimed at

familiarizing the new staff with the processes and functions of the hospital to ease the transition of the new nurses into the organization in general and to the specific units. The program also introduced the nurses to the UAE culture in a form of cultural immersion, where the nurses visited the historical places highlighting the UAE culture. The following excerpt is a segment of data coded from the document review data, under the initial code learning the organization:

> Facility A is a private for-profit organization, and the orientation program introduces the new nurses to the insurance, coding, and billing system. Nurses at this hospital play a key role in the coding and billing of patient care in liaison with the insurance department. The hospital is an accredited Baby Friendly (BFHI) facility, and considerable time in the orientation program is used to raise awareness among the new nurses, and specify their roles in the BFHI program.

Facility B gave a general orientation to all the new staff, and both clinical and non-clinical employees attended. The nursing orientation session was done on the second day of the session. As seen from the excerpt from the coded data from the document under discussion, Facility B focused mainly on the clinical aspects of the organization as relevant to the different disciplines:

> The clinical orientation session is conducted the following day. Only the nursing leadership and the nursing education team attend this session. The new nurses are introduced to the clinical practices and procedures, as well as the general policies. The unit specific procedures are left for the specific units to cover. The duty rosters and shifts are discussed. The infection control nurse then introduces the

hospital's infection control practices and universal precautions. The key themes and categories derived from data related to this question are presented in Table 10.

Table 10

Key Themes and Categories for Research Question 7

Key theme	Categories	Selected excerpt
Supportive organizational climate	Facilitating onboarding	The hospital gave me a visa and I came and joined. They were very good because they paid for my flight and gave me hospital accommodation. (Daisy)
	Promoting intent to stay	When I first came over I was given a mentor for the first four weeks to kind of help me settle in and help me, and that was definitely a huge plus. (Camellia)

Linking Themes and Categories

Axial coding was used to discover the relationships between the categories, such as causal conditions, context, strategies, intervening conditions, and consequences; and theoretical coding was then used to theorize the data and the emergent focused codes. Theoretical sampling was done with the intent to reach theoretical saturation of the category properties, until the major category assimilation was refined.

The causal conditions were the push and pull factors and transnational nurse migration. The push and pull factors acted as stimuli for the nurses to migrate, and transnational nurse migration was the response; and was also the immediate cause of the nurses having to go through professional integration.

The context included transitional anxiety and experience of culture shock. The organization and the nurse leadership influenced the context by applying certain interventions that alleviated or exacerbated the situation. The supportive organization made the situation more comfortable so that the expatriate nurses managed to stay, and some even extended their employment contracts and did not leave.

Intervening conditions were the positive and negative leadership styles and behaviors that either facilitated or inhibited the integration of expatriate nurses. In this study examples of intervening conditions were experience of leadership support, desirable leadership qualities, and optimal leader-member relationships. These positive leadership styles promoted the expatriate nurses' the intent to stay. Negative experiences such as "some of the leaders can shoot you down", feeling unheard, and siloing of ethnic groups and cultural isolation perpetuated by some nurse leaders led to disruption, derailing, and impeding of professional integration of expatriate nurses.

Strategies included using support structures such as family and friends, peer support groups, religion, relaxation, positive imagery, and undergoing professional resocialization. Participants reported difficulties dealing with anxiety until an effective social support system was adopted and used. Intentional professional resocialization also enabled the nurses to integrate into the host country work environment. The peer support groups also facilitated acceptance of the expatriate nurses into the existing social and cultural groups. Some nurse leaders encouraged the existing nurses to accept the new nurses through unit-based partnerships such as preceptorship.

The consequences included striving to adjust, accepting the patients' culture, cultural immersion, and assimilation. Other consequences were breaking of the closed groups by inclusion of new nurses by the nurse leaders, embracing diversity, although the existing nurses did not reciprocate this at times. Figure 1 shows the links between the themes and categories.

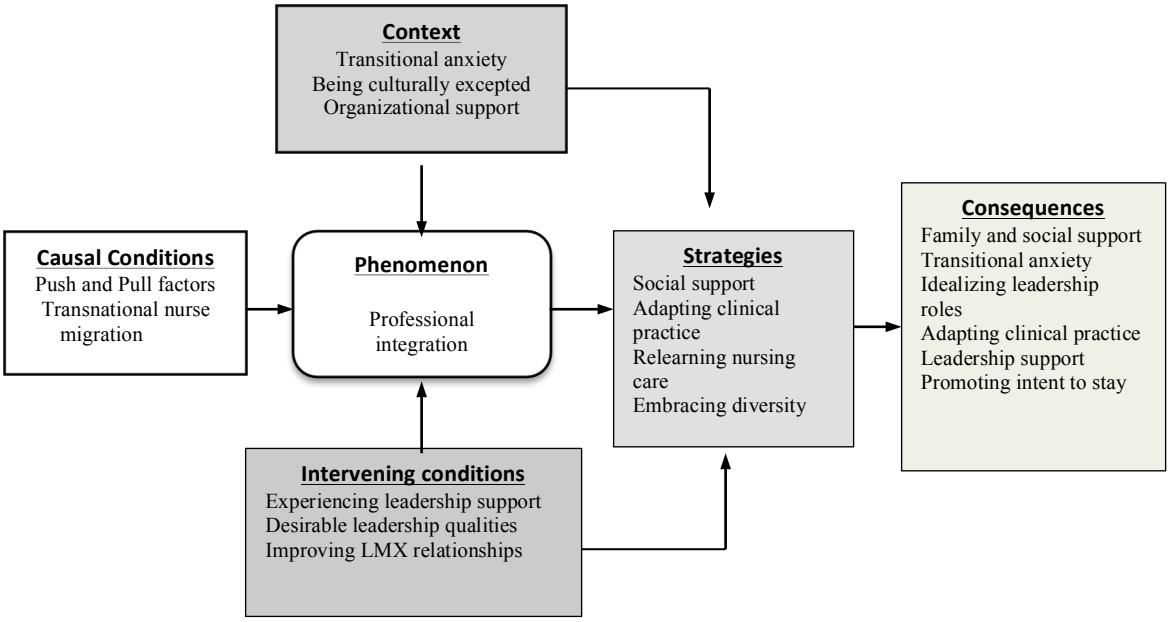

Figure 1. Linking key themes and categories.

Theoretical Explanation

The themes and categories generated from the research questions were linked to develop the conditional assimilation theory. This substantive theory is described in greater detail in Chapter 5 and illustrated in Figure 1. The conditional assimilation theory was developed from, and grounded in the data generated from the qualitative interviews and documents review presented in Chapter 4. The theory explains how the nurse

leadership styles and behaviors influence the professional integration of expatriate nurses newly arrived to the United Arab Emirates.

Summary

I presented in Chapter 4 the results of this study from the data collected through individual qualitative semi-structured interviews, demographic survey, and document analysis. The results were presented by the seven research questions. Charmaz (2014) described the constructivist grounded theory research report as "…an analytic product rather than a purely descriptive account …" (p. 15). The experiences and perceptions of the research participants drove the emerging theoretical constructs that culminated in a substantive theory, the conditional assimilation theory. The resultant explanatory theory helped me not only to gain a deeper understanding of the experiences of the expatriate nurses as they transitioned and adapted to the new work environment, but also to derive a profound comprehension of the dynamics between the nurse leaders and their expatriate nurse followers.

Question one required the expatriate nurses to describe their lived experiences in the new work environment. The theme associated with this question was the expatriate nurses' use of social support structures for comfort and solace due to the anxiety-provoking migration into a new country. To answer the second research question the participants were asked to describe the ideal multicultural work environment that would promote their professional integration, and the theme that emerged was transitional anomie, due to the perceived hopelessness of the expatriate nurses' situation. The third question sought to explore the leadership qualities that would enhance the integration of

professional nurses. The key theme developed from the answers was that ineffective leadership was a barrier to the expatriate nurses engaged in integrating into a new workplace. Question four asked for the perception of the expatriate nurses on the key roles of the nurse leader during their integration process and the key theme related to this was facilitative leadership styles.

Question five was divided into its two component parts that investigated the general experiences of expatriate nurses as they integrated into the organization, and the impact of the differences in practice on the integration process. The resultant themes were breaking exception by inclusion, and professional resocialization. Question six, which explored the interactions between the expatriate nurses and their nurse leaders, yielded the theme supportive leadership behaviors. From question seven, which addressed the role of the organization in the expatriate nurses' integration, produced the theme supportive organizational climate.

Chapter 5 provides the interpretation of the results, the limitations of the study, the recommendations for future studies, and the conclusion. I also present the substantive theory to explain how nurse leadership styles and behaviors influenced the professional integration of expatriate nurses. The implications of the research findings for social change and professional practice are also discussed in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

The specific purpose of this study was to generate a theory that would help to explain how nurse leadership styles and behaviors impact the professional integration of expatriate nurses in the acute care hospitals of the UAE and GCC region. The general purpose was to generate a body of knowledge from which stakeholders involved in the recruitment of international nurses to the UAE and GCC region would draw or derive information to develop and institute programs and strategies to ease the process of transnational migration of nurses. The intent was to go beyond the interactionary processes between the nurse leadership styles, behaviors, and the process of integration of the professional nurses by considering the context of those dynamics through the aspects of organizational culture and interpersonal relations within the new work context.

The constructivist grounded theory approach as described by Charmaz (2014) was used to explore the perceptions of the expatriate nurses in the UAE on the impacts that nurse leadership styles and behaviors had on their process of professional integration. The grounded theory method was used to obtain data from interviews conducted with expatriate nurses within their first year in the UAE, and also to examine documents pertaining to orientation programs designed for the new nurses, with the goal of developing an explanatory theory. The grounded theory approach was selected for this study because it involves inductive data to construct analytical categories and theories from interactions with people and previous experiences (Charmaz, 2014; Corbin & Strauss, 2015).

Summary of the Key Findings

Eight key themes emerged from the analysis of data from the transcribed interviews and reviewed documents. The first theme was that social support structures were comfort zones. Essentially, people trying to adapt to an unfamiliar environment draw upon their social support systems to help them deal with the transition. Having either family or friends for support was critical, and these resources were used as a comfort zone to which those undergoing stressful situations could go for solace and to derive some form of psychological healing. Survival skills were also developed or adopted to assist with dealing with conflict. People avoided direct conflict and preferred to be the victim rather than further antagonize their peers.

The second theme was transitional anomie. Employees need to feel secure and safe in an organization for their psychological well-being and productivity. When the moral fiber of the organization is broken and there is unethical behavior among the employees, this results in feelings of hopelessness in the staff members. This is especially so with newly arrived employees trying to settle into the organization. Unethical behavior such as bullying and discrimination causes discomfort, helplessness, and uncertainty among the expatriate nurses, in addition to the anxiety related to their migrant status. Leadership behaviors that encourage or condone discrimination were seen as contributing to the new employees' feelings of anomie. Usually it is the experienced nurses who migrate abroad, and when previous clinical experience is disregarded their professional self-concept is further diminished.

The third theme was that ineffective leadership was a barrier as some leaders were inclined to make decisions unilaterally and did not take on board what the followers suggested. The expatriate nurses felt working under such a leader discouraged team playing and innovativeness and undermined their professionalism. There was a general desire to improve the leader-member exchange relationship to one of a higher quality to enable the new nurses to fit easier into the workplace. The leaders were perceived as having in-groups and out-groups, and the new nurses felt as long as they were in the out-group it would be difficult to derive any support from or direct interaction with the leader.

The fourth theme was that facilitative leadership behaviors were desirable when the followers were newly arrived in the organization. In this case the followers described the desirable leadership qualities they would have liked to see in their leaders. Most of the expatriate nurses felt that the most effective leaders communicated effectively, guided their followers through setting goals and helping followers to reach them, gave support to the new nurses, were considerate to the vulnerable situation of the new nurses, and motivated their followers to overcome barriers. Effective leaders also played roles such as helping the new nurses solve problems, advocating for the nurses with the top management, and being their voice in the organization. Conversely, negative leaders disrupted the process of integration, added to the anxiety, and encouraged strife among the different groups of followers.

The fifth theme was that some leadership behaviors fostered discrimination and racism and impeded the successful integration of expatiate nurses. The group siloing that

was in inherent in the multicultural workplace exacerbated this. An effective leader strove to unite the culturally diverse followers and formed an effective team through the use of leadership styles that discouraged cultural exception, promoted equity and social justice, and emphasized group cohesion. Staff members were encouraged to communicate using the official language that included all staff members, regardless of their native tongue.

The sixth theme was that for nurses to integrate into the new work environment, they had to undergo professional resocialization. Expatriate nurses come from different professional backgrounds with diverse professional orientations, and face challenges with clinical practice in the new clinical environment. The new nurses had to adapt their clinical practice to suit the new situation, and this frequently involved unlearning old practices and relearning new ways of nursing practice. New technology was cited as posing unique problems, particularly for those coming from places that had very little mechanical or electronic equipment for patient care use. Some nurses embraced new technology and motivated themselves to familiarize themselves with the technology. The role of leadership in encouraging or promoting professional resocialization was critical because it determined the outcome of that process.

The seventh theme that emerged in this study was supportive leadership styles. The nurses engaged in integrating into a new work environment required specific leadership styles that would enable or facilitate that process. The general notion was that supportive leadership styles were more effective in situations in which expatriate nurses were adapting to a new workplace. Affiliative leadership was cited as catering to all the

leadership needs of the new nurses and included motivating people in a stressful situation, empathy, team building in a culturally diverse environment, and showing personal interest in the followers. The other supportive leadership style that helped nurses through to successful integration was culturally intelligent leadership. Although the participants did not use this exact term, they described leader actions such as fairness, cultural blindness, cultural sensitivity, and discouraging cultural exception.

The last theme was supportive organizational climate. The common perception was that the assistance received from the organization facilitated nurses' integration process. Actions by the employing organizations such as paying for the new nurses' flights from their home countries, assisting with processing the professional licenses, and providing accommodations were viewed as very supportive and enabling. Most of the participants regarded this organizational support as a mitigating factor in the transition process. Most of the participants stated that perceived organizational support served to motivate their intent to stay.

Interpretation of the Findings

The major finding in this study was that professional integration of expatriate nurses needed to be mediated by different conditions for those nurses to successfully assimilate into the new multicultural work environment. These findings were not surprising with regard to effective and poor leadership styles, but it was interesting to note that the participants required leadership styles specific to the clearly demarcated process of professional integration to ensure a successful outcome. The process of professional integration was influenced by different conditions such as mediating,

intervening, and enabling conditions. The result of this study was the inductive and abductive development of a substantive theory called Conditional Assimilation Theory.

Conditional Assimilation Theory

This theory explains how leadership styles and certain conditions fit together to affect the process of professional integration of expatriate nurses. In the UAE and the GCC countries, the multicultural nature of the work environments (influencing conditions) and the associated unique dynamics form the backdrop that influences the expatriate nurses' experiences as they endeavor to integrate into the new workplace. The influencing conditions impact the type of leadership behaviors exhibited by the nurse leaders functioning under these conditions.

The driving conditions for the professional integration process are positive leadership actions, which include supportive and facilitative leadership styles. The effectiveness of the driving conditions depends on the force exerted by the restraining conditions (transitional anomie and ineffective leadership). The quality of the mediating conditions (supportive organizational climate and social support structures) influences the driving and restraining conditions. The expatriate nurses are not passive participants and influence the enabling conditions by actively embarking on professional resocialization to facilitate their integration process. The deliberate efforts by nursing leadership to manipulate the work environment, such as breaking down cultural exclusion and creating cross-cultural teams (intervening conditions), further encourages the process of integration, and the expatriate nurses begin to develop a sense of belonging in the organization and start to acculturate into the host society (intent to stay and

acculturation). The final outcome condition of the actions of the different conditions is assimilation into the new work environment. Unhealthy integration results from loss of fit among and unequal forces exerted by the conditions affecting professional integration of expatriate nurses. The conditional assimilation theory is shown in Figure 2.

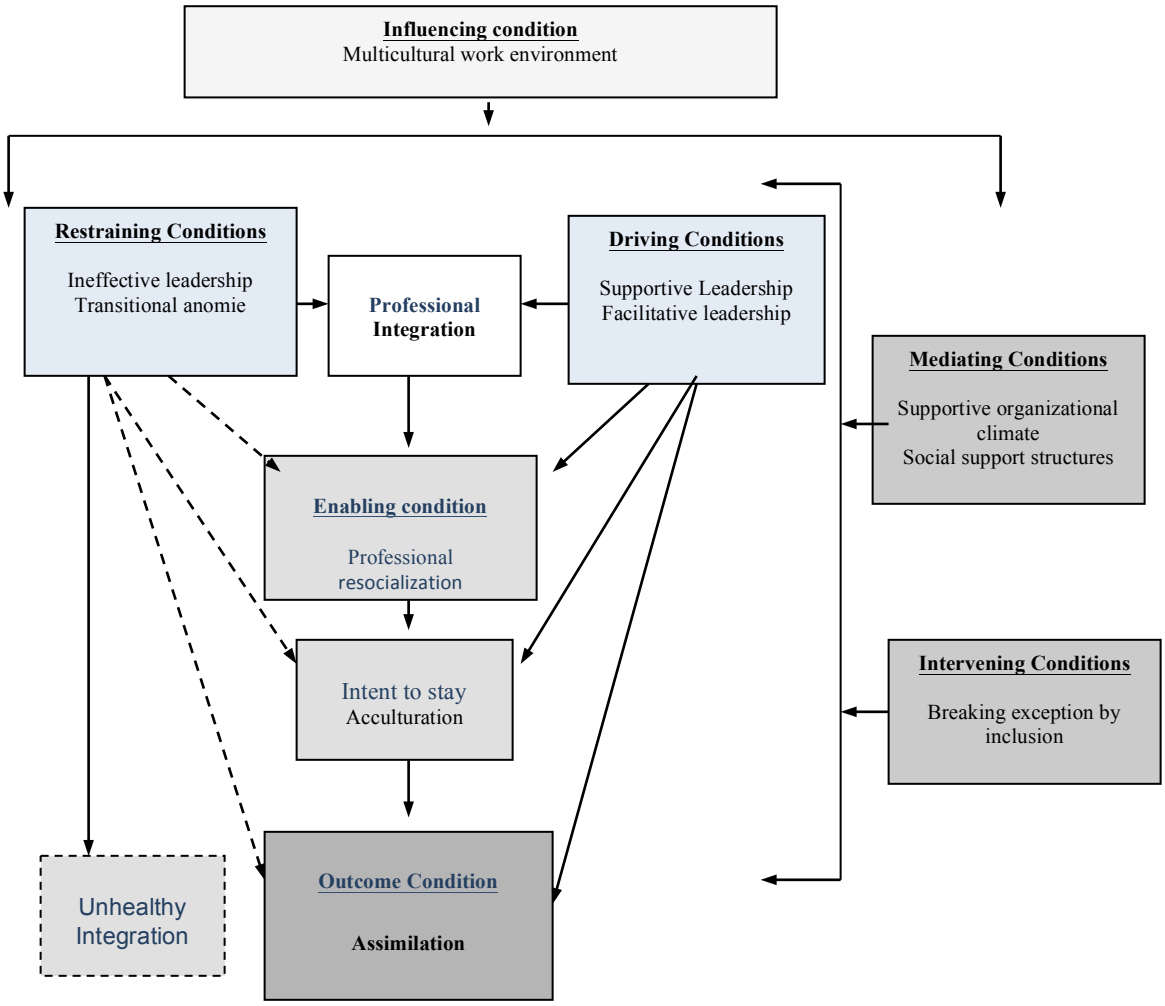

Figure 2. The conditional assimilation theory.

Study Findings in Context of the Theoretical Framework

Although grounded theory research is conducted to generate a theory rather than test a theory, this study included two theoretical frameworks as lenses or perspectives

through which the concepts related to the phenomenon of interest (professional integration of nurses vis-à-vis nursing leadership styles) were studied. Meleis's (2010) transitions theory provided the theoretical perspective to study the process of professional integration, which is related to the process of transitioning into a new environment. Bass and Avolio's full range of leadership model guided the study of leadership styles and behaviors. The study findings are discussed within the context of these two theoretical frameworks.

Meleis's transitions theory. According to Meleis (2010), migration to other places is an example of situational transitions. From the findings in this study, the transition or passage from one fairly stable state to another fairly stable state is the process of professional integration. The expatriate nurses did not only embark on adapting to the new workplace, but they also had to unlearn some of their old practices and adopt new ones. Therefore, the pattern of the transition could be referred to as simultaneous transitions. The properties of transitions that the expatriate nurses went through were change and difference, where they experienced changes in their roles, patterns of behavior, and identities. Most of the changes in the roles and identities could be explained by the categories adapting clinical practice and subjugated professional autonomy and the key theme from Research Question 2: transitional anomie.

Transition conditions, the facilitators or inhibitors of healthy transition, are captured by the key themes from Research Questions 3 (ineffective leadership is a barrier), 4 (facilitative leadership behaviors), 6 (supportive leadership styles), and 7 (supportive organizational climate). Nursing therapeutics in Meleis's (2010) transitions

theory refer to actions that nurses can take to prepare the patient for or assist the patient in the transition, and are synonymous with the actions the expatriate nurses took to enable themselves to transition as well as possible. In the current study, the expatriate nurses made a decision to go through professional resocialization, which meant relearning how to practice nursing, accepting lower professional roles and loss of autonomy, embracing cultural diversity in relation to peers and patients, and using social support systems as coping strategies. Nursing therapeutics from the nurse leaders' part were the efforts at breaking down the ethnic silos to create a multicultural work group, as described by the categories breaking exception by inclusion and culturally intelligent leadership.

The final concepts in the transitions theory are process indicators that include feeling connected, developing confidence and coping; and outcome indicators, which are concerned with mastery and fluid integrative identities (Meleis, 2010). The positive processes indicators reported by the research participants were promotion of intent to stay and feeling empowered, and the negative ones included being culturally excluded. The positive outcome indicators were represented by the emergent themes acculturation and assimilation. Transitional anomie could be described as the unhealthy outcome indicator of the transition called professional integration of expatriate nurses. Transitions, according to Meleis (2010), are dependent upon certain conditions and situations. Similarly, the outcome of professional integration of expatriate nurses depends upon leadership styles and behaviors in conjunction with certain conditions and situations.

Bass and Avolio's FRL theory. The premise of the FRL model is that effective leaders should use more than leadership style where one style builds upon the strengths of

one style and other styles cover the deficit caused by another style's weaknesses (Bass & Avolio, 1994). The participants in this study described the different leadership styles and behaviors exhibited by their nurse leaders and also idealized leadership styles they wished to see in their leaders.

Transformational leadership. Transformational leaders motivate their followers to perform beyond their own expectations, which was mentioned by some of the participants. For example, Dahlia felt that her leader was being effective by setting goals for the staff and encouraging them to work towards achieving those goals. The TFL factor, intellectual stimulation, refers to a leader with great influence through being solution-oriented. Participant Daisy described a leader exhibiting the TFL factor of individualized consideration when she stated that she wished to be treated as an individual person with unique needs. Camellia, alluding to the TFL factor of inspirational motivation, said that even though she was an experienced nurse, she still encountered problems adapting to the new work environment, and needed compassion and support from the leader. Finally, the TFL factor of idealized influence was experienced by Oleander when he described his leader as exhibiting supportive leadership behaviors in relation to the Path-goal theory of leadership.

Transactional leadership. The premise of transactional leadership style is that the leader motivates the followers through giving them rewards in exchange for higher performance (Ali et al., 2015). Contingent rewards were experienced in the form of appreciation and praise for a job well done, as reported by participants Petunia and Oleander. Some participants reported having experienced the factor of transactional

leadership called management by exception (passive), where they were reprimanded or punished for making mistakes, and some had their days off cancelled for being off sick.

Laissez faire. The laissez faire leadership style was not experienced by any of the research participants, but was referred to as an ineffective leadership style they would not like to see in their leader. In such cases the leader did not guide them or show them what to do.

Findings Confirming Knowledge

Some findings from this study supported the information found in the existing literature described in Chapter 2. These included professional licensure and leadership influence on the work atmosphere and organizational outcomes.

Professional nursing licensure. Obtaining a nurse license was cited as a barrier to nurses in the host country because the process of licensure was not clear, frustrating, and took considerable time. As a result the nurses spent a long time before starting work (Ho &Chiang, 2015). In addition, Moyce et al. (2015) found that due to delays in getting nurses' licenses, the expatriate nurses ended up taking lower jobs to survive the interim period. In this study, the expatriate nurses reported similar experiences with getting the eligibility letter for registration that their employer would then use to sponsor the nursing license. Participant Oleander had to get a job as a porter at the hospital while he was waiting for his nursing license to be processed. Other participants, such as Rose stated,

> One thing I found frustrating, it took me two months to get my licence, so I was there for two months before I had my nursing licence. Unfortunately before I left London to come to Dubai it wasn't made clear to me of what would be involved

> in obtaining your licence. It meant, I trained in Dublin in Ireland, they wanted information from there, which is over 20 years old, and they wanted information from London. It is just very complicated. Maybe if they gave the expats an idea of the information needed then it would help someone integrate, and to be able to plan and organize their documents much better before they came to Dublin or the UAE in general.

Leadership influence. Many researchers found that leadership behaviors and styles had an effect on the work atmosphere, the staff wellbeing, and the success of the organization. Two indicators of effective leadership, employee intent to stay and organizational citizenship behavior, were apparent in the findings from this study.

Intent to stay. The participants perceived support from both the leader and the organization. They then decided to stay with the organization and to endure all the negative experiences until they had adapted into the new work place.

Organizational citizenship behavior. The participants reported feeling safe and developed a sense of belonging when they perceived their leader exhibiting people-centered and values-based leadership behaviors. These included showing interest in each individual new nurse, supporting them, and showing cultural sensitivity and cross-cultural team building. According to participant Oleander, this motivated him to perform as best as he could.

Deskilling. Nurses migrating to other countries reported that they experienced deskilling, where they where given jobs with a lower entry level regardless of their previous experience in the home countries (Moyce et al., 2015). The expatriate nurses in

the UAE had a similar experience. Camellia, a nurse with over 10 years nursing experience lamented:

> Back home in Ireland you are more independent and able to make your own decisions, and you will only consult a doctor if you have any concerns or you have any worries. Whereas here I feel like if you have to anything it has to go through a doctor, so I am definitely struggling with that aspect.

Findings Disconfirming Knowledge

Although the literature contains reports of both good and unpleasant conditions and experiences faced by migrant nurses, some findings in this study conflicted with some of the findings in the extant peer-reviewed literature. For example, enculturation has been cited as a barrier to successful professional integration**.** Previous studies found that the nature of the nurses' enculturation, or social cultural, and professional socialization determined the outcome of their adaptation efforts in the new country (Alexis, 2015; Willis & Xiao, 2014). These nurses were expected to have difficulties forming social and cultural ties with the host society and to adapt within a perceived different station in life because they had been brought up to believe they came from a certain tier in life. This was not the case in this study. The research participants were drawn from developed countries such as the United Kingdom and Ireland, emerging strong economies such as India, the Middle East (Jordan), and the developing countries (Nigeria, the Philippines). All the participants reported similar experiences in the UAE. It was the acculturation challenges, rather than enculturation, that were the main barrier to successful integration of the expatriate nurses.

Findings Extending Knowledge

Most research studies conducted in the UAE and GCC focused mostly on the cross-cultural dynamics between the expatriate nurses and the nurses. Bealer and Bhanugopan (2014) addressed transformational and transactional leadership within the UAE context. According to Bealer and Bhanugopan (2014), and El Amouri and O'Neill (2014), the demographic picture of the UAE is such that more than 80% of workers are foreigners. The current study found that expatriate nurses felt that affiliative leadership behaviors and styles were more effective in facilitating their professional integration into the multicultural work environment of the acute care hospitals of the UAE. From this perspective, it could be generalized that affiliative leadership styles can be used in the UAE workplaces, regardless of the nature of the workplace.

Limitations of the Study

Qualitative research has inherent limitations that are peculiar to the research tradition, and these limitations had an impact on this study. These limitations also serve a positive effect that makes qualitative research valuable. For example the small sample sizes used in qualitative research studies may limit the generalizability of the research findings to similar situations on one hand, but also enable a deeper and richer understanding of the generated data. My study sample was information-rich because it consisted only of expatriate nurses all going through similar phenomena of integrating into the multicultural workplaces of the acute care hospitals in the UAE. The participants were drawn from a broad range of years of nursing experience and donor countries to maximize representativeness of the study population and credibility of the study. The

study findings, however, may only be transferable within the UAE and GCC region as this geographical region shares similar religious, cultural, and economic similarities. Data in this study were generated from self-reporting of experiences, and this subjectivity could have impacted on the reliability of the findings, but the intent was to allow the participants' voices to be heard. This meant that the participants' interpretations of their experiences were taken as an accurate account of that experience.

Most of the participants preferred telephone interviews, limiting the studying of non-verbal cues and facial expressions that could have allowed better understanding of the participants' description of their experiences. Conversely, telephone interviews could have encouraged the participants to speak freely because they were only "seeing" my voice and not been limited by my physical presence. The telephone interviews could also have resulted in richer data because the participants had time to think about their answers (see Ward et al., 2015). The perceptions of the small sample of expatriate nurses may have been distorted by my biases with the phenomenon under study.

Recommendations

Although I sought in this study to explore how nurse leadership styles and behaviors impacted on the professional integration of expatriate nurses, other areas were briefly touched during this research study, but could not be fully addressed at this time due to the limited scope of the study. Future research could expand on the concept of assimilation and investigate how the new employees assimilate into the culturally diverse UAE health care and other organizations. Another area that was highlighted by this study and warrants further empirical investigation was how the healthcare organizations would

deal with discrimination and racism. Another recommendation is to explore in detail the perceptions of the nurse leaders on how leadership styles influence the work environment in the health care organizations.

Social support systems were used by almost all the participants to help them cope with the anxiety and stress of transitioning into a new country. Future research could investigate the role of, or how effective social media such as WhatsApp would be with helping people reach out to others for moral support. Prospective research studies could be conducted to evaluate the efficacy of practices implemented to help the integration of new staff, or the adoption of certain leadership programs aimed at improving leader-member relationships and staff retention.

Implications

Social Change Implications

The results of this study have indicated how the expatriate nurses in the UAE experience their process of professional integration into the new multicultural work environment. The newly arrived nurses described how they pooled social support resources to help each other to cope with anxiety during the transition period. By removing or minimizing the stressors that the new nurses experience in the first few months of arrival, the healthcare organizations can influence positive social change. An example would be recruiting married nurses on a visa that automatically includes the family members to maintain the intactness of the family unit. The human resources departments could ease the licensing process by informing the prospective employees

beforehand the required documents, and warn them of the approximate time it would take to obtain the professional license to practice nursing.

Orientation programs for new employees should focus more on adapting to an unfamiliar environment, the UAE local culture, and briefly discuss the general patient demographics in the patient catchment area. Counseling programs could be developed to assist the new nurses to talk about their anxieties with a trained individual and also get professional help to deal with the transitional anxiety. In addition to the preceptorship system that exists in most health care organizations, more robust unit-based support systems with direct nurse leader oversight could be developed to ensure healthy adaptation of the new nurses.

Implications for Theory

This study helped to increase the understanding of the dynamics and interactional processes between the nurse leaders and their expatriate followers. The conditional assimilation theory will add to the body of knowledge that seeks to understand the leader-follower relationships and the impacts on the organizational outcomes. Most of the research participants mentioned that the positive leadership styles and behaviors were essential for facilitating professional integration. The positive leader influences needed to be stronger than the negative ones to avoid impeding the whole process. The new nurses used support systems as a place they could go to when they needed to escape from the stressful situation. Organizations and department leaders can ensure all the conditions in the conditional assimilation theory are present and balanced when they implement

systems and programs to promote the professional integration of newly arrived expatriate nurses.

Implications for Practice and Policy

The significant study findings included culture shock that ranged from dealing with the culturally diverse UAE society, culturally diverse work colleagues, and inclination by cultural groups to stick to their own and exclude the other cultural groups. The health care organizations should follow the example of the UAE government of cultural inclusiveness. There are more than 200 nationalities living in the UAE, and they all come in under the same visa and employment stipulations. The UAE labor laws treat no cultural group differently. However, in this study discrimination and racism were found to be quite common in the acute care hospitals of the UAE. This was exemplified by the in vivo code "we the non-Westerners." Health care organizations and other employers should develop, implement, and enforce policies that promote cultural diversity and should discourage discriminatory practices. Systems and processes that ensure anonymity should be put in place through which employees can report to senior management or similar, any instances of racial or cultural discrimination.

The participants reported that positive leadership behaviors facilitated their professional integration into the new workplace, and the negative behaviors impeded their successful integration. Organizations should implement training programs to equip their leaders with the necessary skills to promote a healthy work environment, and to drive and motivate a multicultural work group towards achieving the organizational

goals. People-centered and supportive leadership styles centered and were cited as more effective in leading a multicultural team.

Conclusion

Transnational nurse migration is set to prevail as long as there continues to be a higher demand of nurses by the developed countries. This migration involves certain experiences, and nurses recruited from overseas will still have to undergo adaptation, adjustments, and professional resocialization in the recipient work environment. In this study constructivist grounded theory approach was used to explore the leader-follower interactions and processes that led to the successful integration of the expatriate nurses.

Eight themes emerged from this study, and the first theme was that social support structures are used as comfort zones. The second theme was that some actions in the new work environment could cause transitional anomie among the newly arrived nurses. The third theme was that ineffective leadership could be a barrier to the professional integration of expatriate nurses. The fourth theme was that facilitative leadership behaviors were idealized as promoting the expatriate nurses' integration process. The fifth theme was that interventions such as breaking exception by inclusion encouraged the integration process. The sixth theme was that the decision to undergo professional resocialization was an enabling action for professional integration. The seventh theme was that supportive leadership styles such as affiliative leadership were more effective forms of leadership in the multicultural work environments of the UAE. The final theme was that supportive organizational climates also contributed to the integration process of

the expatriate nurses. Linking these themes led to the emergence of the middle range conditional assimilation theory.

The study findings indicate that nurse leadership behaviors are largely dependent on the surrounding conditions, and these conditions could be manipulated to foster healthy professional integration of expatriate nurses. Actions such as developing and implementing training programs for nurse leaders could help to engender conditions that support successful integration, adaptation, and assimilation of expatriate nurses into the new work environment.

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Appendix A: Interview Guide

Introductory Questions

1. Before we begin the discussion, do you have any questions for me?

RQ 1. What are the lived experiences of expatriate nurses in a new work environment?

1. Please tell me about the first time you arrived to the UAE?
2. What aspects of the new work environment were different from your home country?
3. Can you describe your experiences in the first few months in your current hospital?

RQ 2. How would you describe the ideal multicultural work environment that would promote the professional integration of expatriate nurses?

1. What do you understand about the term multicultural work environment?
2. Can you describe the ideal environment to support professional integration of nurses?

   (Probe: Why do you think so?)
3. What about an environment that would impede professional integration?

RQ 3. What leadership qualities would enhance the integration of expatriate nurses?

1. What are your thoughts about leadership qualities in the workplace?
2. What are the qualities a leader should have to promote integration of expatriate nurses?

3. Can you describe the leadership behaviors that would hamper integration of expatriate nurses?

RQ 4. What do you perceive as the key roles of a nurse leader in the professional integration of expatriate nurses?

1. What role does the nurse leader play in the day-to-day work?
2. What specific roles do you think would enable a nurse leader to facilitate the integration of expatriate nurses?

RQ 5. What are the general experiences of expatriate nurses as they integrate into the destination healthcare organization?

1. What do you think are the general experiences of expatriate nurses in the host work environment?
2. How do you think the interpersonal relationships impact the integration of the new nurses?
3. Can you describe how the differences in nursing practice impacted on your integration experience?
4. What resources did you use to cope with the different work environment?

RQ 6. What specific interactions with nurse leaders impacted on the expatriate nurses' integration process?

1. Please describe an instance where you felt that your leader positively influenced your stay on the nursing unit
2. What about a situation when you felt your leader could have done more to ensure your smooth adaptation into the unit?

RQ 7: To what extent did the organizational cultural and structural factors influence the expatriate nurses' integration process?

Additional notes:

Appendix B: Demographic Survey Form

Contact Information

1) **Please provide the following contact information:**

First and Last Name:
_____

Address: _____

City: _____ Emirate _____

Phone Number: _____

Email Address: _____

2) **Which way do you prefer to be contacted?** □ Phone □ Email

3) **How many years have you lived in the United Arab Emirates?**

□ Less than 1 year □ 1-2 years □ 3-10 years □ Over 10 years, but not all my life □ All of my life

Basic Information

4) **Gender:** □ Female □ Male

5) **Age:** □ Less than 25 years □ 25-30 years □ 31-40 years □ 41 years and above □ Prefer not to say

6) **Years of Post-Graduate Nursing Experience**

□ Less than 1 year □ 1- 3 years □ 4 -10 years □ Over 10 years

7) **Is this your first posting abroad?** □ Yes □ No (Please Give Details)

_____

8) **Racial/Ethnic Identity:**

□ Emirati

□ Indian

□ Filipino

□ Arab (GCC/Specify) _____

□ Arab (North African)

□ Arab (Other/Specify) _____

□ African (Sub-Saharan/Specify) _____

□ European (Specify) _____

□ Other (Specify) _____

9) **What, if any, is your religious preference?**

□ Muslim

□ Hindu

□ Christian (Catholic)

□ Christian (Other/Specify) _____

□ Orthodox

□ Buddhist

□ Other (Specify) _____

□ No Preference / No religious affiliation

□ Prefer not to say

Career

10) **What is your current career status?**

□ Employed full-time

□ Employed part-time

11) Did you receive transcultural nursing education in your country?

□ Yes □ No

12) Did your nursing curriculum include nursing leadership? □ Yes □ No

Appendix C: Letter of Request for Participation

Letter of Request for Participation

Date:

Dear Potential Participant

My name is Emmah Ncube and I am a PhD student with Walden University, USA, and undertaking doctoral dissertation/thesis research as part of my degree program. My research study will seek to explore how nurse leadership styles and behaviors impact the professional integration process of internationally recruited nurses within their first year in employment in the United Arab Emirates (UAE). The goal of this research is to generate a theory that will create recommendations for policy change that will ease and alleviate the integration process of expatriate nurses into the UAE nursing work force. The long-term goals of this research are to expand the research to the Gulf Cooperation Council region and finally to the Middle East region.

With the agreement of local heath regulation authorities and my university Institutional Review Board, this letter is being distributed to all expatriate nurses (internationally recruited nurses) at your hospital who have joined the hospital within the past twelve months. The methodology for this study will be to conduct semi-structured individual interviews, either face-to-face or telephone interviews, where written questions will guide the interviews. Since this is a grounded theory study I may need to interview you more than once just to clarify some queries and to build up on the developing theory. This study will contribute to the body of nursing knowledge and to positive social change that will facilitate seamless professional integration of expatriate nurses in the UAE.

Participation in this research is completely voluntary, participation/results of the research will be kept strictly confidential from the employers, and anonymity will be observed to protect your identity. You will be free to withdraw from the study at any time without

any problems. Data analysis will produce themes that will be used to build up a theory, and it is these themes and the theory that will be published, with no specific information about your participation. The time commitment is approximately 1 hour individual interview either face-to-face or telephonically. I will be audio-recording the interviews so that I can transcribe them and type them. I will keep the audiotape in my home safe under lock and key.

If you are interested in volunteering for this research I ask that you contact me within the next week by phone 0509770127, or email address emmahnck@yahoo.co.uk.

Thank you very much for you consideration.

……

Emmah Ncube, MSN, RN, RM

Appendix D: Letter of Cooperation with a Research Partner

Letter of Cooperation from a Research Partner

X Hospital
United Arab Emirates

Date:…….

Dear Emmah Ncube,

Based on my review of your research proposal, I give permission for you to conduct within X Hospital Dubai/Abu Dhabi, UAE, the study entitled Nurse Leadership Styles, Behaviors, and the Professional Integration of Expatriate Nurses in the United Arab Emirates and the GCC Region. As part of this study, I authorize you to approach through emails the expatriate nurses within their first year of employment at X Hospital, where the email addresses will be obtained through the designated person; to conduct face-to-face and/or telephone interviews to collect data, to telephone and/or meet with the research participants face-to-face to confirm the authenticity of the collected data (member-checking) and to disseminate the research findings through a presentation at X Hospital. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: Provision of a private space for the individual face-to-face qualitative interviews for the research participants not willing to be interviewed in their homes. We reserve the right to withdraw from the study at any time if our circumstances change.

The student will be responsible for complying with our site's research policies and requirements, including observing the ethical considerations of respect for persons, beneficence, justice; human subjects research, and shall share with the organization the study findings. The student will also be responsible for all the costs associated with conducting research at X Hospital.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,
……..
X Hospital, Dubai/Abu Dhabi
United Arab Emirates

Appendix E: Data Use Agreement

DATA USE AGREEMENT

This Data Use Agreement ("Agreement"), effective as of 01 February 2017 ("Effective Date"), is entered into by and between Emmah Ncube ("Data Recipient") and X Hospital, United Arab Emirates ("Data Provider"). The purpose of this Agreement is to provide Data Recipient with access to a Limited Data Set ("LDS") for use in scholarship/research **in accord with laws and regulations of the governing bodies associated with the Data Provider, Data Recipient, and Data Recipient's educational program.** In the case of a discrepancy among laws, the agreement shall follow whichever law is more strict.

1. Definitions. Due to the project's affiliation with Laureate, a USA-based company, unless otherwise specified in this Agreement, all capitalized terms used in this Agreement not otherwise defined have the meaning established for purposes of the USA "HIPAA Regulations" and/or "FERPA Regulations" codified in the United States Code of Federal Regulations, as amended from time to time.

2. Preparation of the LDS. Data Provider shall prepare and furnish to Data Recipient a LDS in accord with any applicable laws and regulations of the governing bodies associated with the Data Provider, Data Recipient, and Data Recipient's educational program.

3. Data Fields in the LDS. **No direct identifiers such as names may be included in the Limited Data Set (LDS).** In preparing the LDS, Data Provider shall include the **data fields specified as follows**, which are the minimum necessary to accomplish the project:

    a. E-mail addresses of prospective research participants

    b. Orientation programs for new staff,

    c. Transcultural nursing orientation programs

4. Responsibilities of Data Recipient. Data Recipient agrees to:

    a. Use or disclose the LDS only as permitted by this Agreement or as required by law;

    b. Use appropriate safeguards to prevent use or disclosure of the LDS other than as permitted by this Agreement or required by law;

    c. Report to Data Provider any use or disclosure of the LDS of which it becomes aware that is not permitted by this Agreement or required by law;

d. Require any of its subcontractors or agents that receive or have access to the LDS to agree to the same restrictions and conditions on the use and/or disclosure of the LDS that apply to Data Recipient under this Agreement; and

e. Not use the information in the LDS to identify or contact the individuals who are data subjects.

5. Permitted Uses and Disclosures of the LDS. Data Recipient may use and/or disclose the LDS **for the present project's activities only.**

6. Term and Termination.

a. Term. The term of this Agreement shall commence as of the Effective Date and shall continue for so long as Data Recipient retains the LDS, unless sooner terminated as set forth in this Agreement.

b. Termination by Data Recipient. Data Recipient may terminate this agreement at any time by notifying the Data Provider and returning or destroying the LDS.

c. Termination by Data Provider. Data Provider may terminate this agreement at any time by providing thirty (30) days prior written notice to Data Recipient.

d. For Breach. Data Provider shall provide written notice to Data Recipient within ten (10) days of any determination that Data Recipient has breached a material term of this Agreement. Data Provider shall afford Data Recipient an opportunity to cure said alleged material breach upon mutually agreeable terms. Failure to agree on mutually agreeable terms for cure within thirty (30) days shall be grounds for the immediate termination of this Agreement by Data Provider.

e. Effect of Termination. Sections 1, 4, 5, 6(e) and 7 of this Agreement shall survive any termination of this Agreement under subsections c or d.

7. Miscellaneous.

a. Change in Law. The parties agree to negotiate in good faith to amend this Agreement to comport with changes in federal law that materially alter either or both parties' obligations under this Agreement. Provided however, that if the parties are unable to agree to mutually acceptable amendment(s) by the compliance date of the change in applicable law or regulations, either Party may terminate this Agreement as provided in section 6.

b. Construction of Terms. The terms of this Agreement shall be construed to give effect to applicable federal interpretative guidance regarding the HIPAA Regulations.

c. No Third Party Beneficiaries. Nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

d. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

e. Headings. The headings and other captions in this Agreement are for convenience and reference only and shall not be used in interpreting, construing or enforcing any of the provisions of this Agreement.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf.

DATA PROVIDER	**DATA RECIPIENT**
Signed: _____	Signed: _____
Print Name: _____	Print Name: _____
Print Title: _____	Print Title: _____